House of Representatives

General Assembly

File No. 504

February Session, 2004

Substitute House Bill No. 5669

House of Representatives, April 7, 2004

The Committee on Judiciary reported through REP. LAWLOR of the 99th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING MEDICAL MALPRACTICE INSURANCE REFORM.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective from passage*) (a) In all civil actions brought to recover damages resulting from personal injury or wrongful death, whether in tort or in contract, in which it is alleged that such injury or death resulted from the negligence of a health care provider, there shall be a program of mandatory mediation. The purpose of such mandatory mediation shall be to (1) review the certificate of good faith filed pursuant to section 52-190a of the general statutes, as amended by this act, to determine whether there are grounds for a good faith belief that the defendant has been negligent in the care or treatment of the claimant, (2) attempt to achieve a prompt settlement or resolution of the case, and (3) expedite the litigation of the case.

(b) Upon the filing of the answer in such action by the defendant,

the clerk of the court for the judicial district in which the case is pending shall refer the case to a judge of the superior court for mediation. The mediation shall take place not later than the filing of the answer or as thereafter continued by the court. The mediation shall not stay or delay the prosecution of the case, nor delay discovery in or the trial of the case.

(c) At the mediation, the court shall review the certificate of good faith filed pursuant to section 52-190a of the general statutes, as amended by this act, to determine whether there are grounds for a good faith belief that the defendant has been negligent in the care or treatment of the claimant. If the court determines that the certificate of good faith is inadequate to permit such a determination, it may order the party submitting the certificate to file, within thirty days, a supplemental certificate setting forth the grounds for the opinion that there has been negligence in the care or treatment of the claimant.

(d) If the court determines that the certificate of good faith or any supplemental certificate is inadequate to support a determination that there are grounds for a good faith belief that there has been negligence in the care or treatment of the claimant, it shall order the party asserting such a claim to post a cash or surety bond in the amount of five thousand dollars as a condition of continuing the prosecution of the case, which bond shall be used to pay the taxable costs of the other party, as permitted by the general statutes, in the event of the unsuccessful prosecution of the case.

(e) All parties to the case, together with a representative of each insurer that may be liable to pay all or part of any verdict or settlement in the case, shall attend the mediation in person, unless attendance by means of telephone is permitted upon written agreement of all parties or written order of the court.

(f) If the mediation does not settle or conclude the case, the court shall enter such orders as are necessary to narrow the issues, expedite discovery and assist the parties in preparing the case for trial.

Sec. 2. Section 52-190a of the general statutes, as amended by section 14 of public act 03-202, is repealed and the following is substituted in lieu thereof (*Effective from passage and applicable to actions filed on or after said date*):

(a) No civil action or apportionment complaint shall be filed to recover damages resulting from personal injury or wrongful death occurring on or after October 1, 1987, whether in tort or in contract, in which it is alleged that such injury or death resulted from the negligence of a health care provider, unless the attorney or party filing the action or apportionment complaint has made a reasonable inquiry as permitted by the circumstances to determine that there are grounds for a good faith belief that there has been negligence in the care or treatment of the claimant. The complaint, **[**or**]** initial pleading or apportionment complaint shall contain a certificate of the attorney or party filing the action or apportionment complaint that such reasonable inquiry gave rise to a good faith belief that grounds exist for an action against each named defendant or for an apportionment complaint against each named apportionment defendant. **[**For the purposes of this section, such good faith may be shown to exist if the claimant or his attorney has received a written opinion, which shall not be subject to discovery by any party except for questioning the validity of the certificate,**]** To show the existence of such good faith, the claimant or such claimant's attorney, and any apportionment complainant or such apportionment complainant's attorney, shall obtain a written and signed opinion of a similar health care provider, as defined in section 52-184c, which similar health care provider shall be selected pursuant to the provisions of said section, that there appears to be evidence of medical negligence and includes a detailed basis for the formation of such opinion. Such written opinion shall not be subject to discovery by any party except for questioning the validity of the certificate. The claimant or such claimant's attorney, and any apportionment complainant or such apportionment complainant's attorney, shall retain the original written opinion and shall attach a copy of such written opinion, with the name and signature of the similar health care provider expunged, to such certificate. The similar

health care provider who provides such written opinion shall not, without a showing of malice, be personally liable for any damages to the defendant health care provider by reason of having provided such written opinion. In addition to such written opinion, the court may consider other factors with regard to the existence of good faith. If the court determines, after the completion of discovery, that such certificate was not made in good faith and that no justiciable issue was presented against a health care provider that fully cooperated in providing informal discovery, the court upon motion or upon its own initiative shall impose upon the person who signed such certificate or a represented party, or both, an appropriate sanction which may include an order to pay to the other party or parties the amount of the reasonable expenses incurred because of the filing of the pleading, motion or other paper, including a reasonable attorney's fee. The court may also submit the matter to the appropriate authority for disciplinary review of the attorney if the claimant's attorney or apportionment complainant's attorney submitted the certificate.

(b) If a claimant in a civil action asserts a claim against an apportionment defendant pursuant to subsection (d) of section 52-102b, the requirement under subsection (a) of this section that the attorney or party filing the action make a reasonable inquiry and submit a certificate of good faith shall be satisfied by the submission of a certificate of good faith by the apportionment complainant pursuant to subsection (a) of this section.

[(b)**]** (c) Upon petition to the clerk of the court where the action will be filed, an automatic ninety-day extension of the statute of limitations shall be granted to allow the reasonable inquiry required by subsection (a) of this section. This period shall be in addition to other tolling periods.

Sec. 3. Section 19a-17a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Upon the filing of any medical malpractice claim against an individual licensed pursuant to chapter 370 to 373, inclusive, 379 or

383, the plaintiff or the plaintiff's attorney shall mail a copy of the complaint to the Department of Public Health and the Insurance Department.

(b) Upon entry of any medical malpractice award by a court or upon the parties entering a settlement of a malpractice claim against an individual licensed pursuant to chapter 370 to 373, inclusive, 379 or 383, the entity making payment on behalf of a party or, if no such entity exists, the party, shall **[**notify**]** provide to the Department of Public Health and the Insurance Department notice of the terms of the award or settlement and **[**shall provide to the department**]** a copy of the award or settlement and the underlying complaint and answer, if any. Such notice and copies provided to the Insurance Department shall not identify the parties to the claim. The Department of Public Health shall send the information received from such entity or party to the state board of examiners having cognizance over any individual licensed pursuant to chapter 370 to 373, inclusive, 379 or 383 who is a party to the claim. The **[**department**]** Department of Public Health shall review all medical malpractice claims, awards and **[**all**]** settlements to determine whether further investigation or disciplinary action against the providers involved is warranted. On and after October 1, 2004, such review shall be conducted in accordance with the guidelines adopted by the Department of Public Health, in accordance with section 20-13b, as amended by this act, to determine the basis for such further investigation or disciplinary action. Any document received pursuant to this section shall not be considered a petition and shall not be subject to **[**the provisions of**]** disclosure under section 1-210, as amended, unless the **[**department**]** Department of Public Health determines, following completion of its review, that further investigation or disciplinary action is warranted. As used in this subsection, "terms of the award or settlement" means the rights and obligations of the parties to a medical malpractice claim, as determined by a court or by agreement of the parties, and includes, but is not limited to, (1) for any individual licensed pursuant to chapter 370 to 373, inclusive, 379 or 383 who is a party to the claim, the type of

healing art or other health care practice, and the specialty, if any, in which such individual engages, (2) the amount of the award or settlement, specifying the portion of the award or settlement attributable to economic damages and the portion of the award or settlement attributable to noneconomic damages, and (3) if there are multiple defendants, the allocation for payment of the award or settlement between or among such defendants.

(c) No release of liability executed by a party to which payment is to be made under a settlement of a malpractice claim against an individual licensed pursuant to chapter 370 to 373, inclusive, 379 or 383 shall be effective until the attorney for the entity making payment on behalf of a party or, if no such entity exists, the attorney for the party, files with the court an affidavit stating that such attorney has provided the information required under subsection (b) of this section to the Department of Public Health and the Insurance Department.

(d) The Commissioner of Public Health and the Insurance Commissioner shall each develop a system within the commissioner's respective agency for collecting, storing, utilizing, interpreting, reporting and providing public access to the information received under subsections (a) and (b) of this section. Each commissioner shall report the details of such system with respect to the commissioner's agency to the joint standing committees of the General Assembly having cognizance of matters relating to public health and insurance on or before October 1, 2004, in accordance with section 11-4a.

Sec. 4. Section 20-13b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

The Commissioner of Public Health, with advice and assistance from the board, may establish such regulations in accordance with chapter 54 as may be necessary to carry out the provisions of sections 20-13a to 20-13i, inclusive, as amended by this act. On or before July 1, 2004, such regulations shall include, but need not be limited to: (1) Guidelines for screening complaints received to determine which complaints will be investigated; (2) a prioritization system for

conducting investigations to ensure prompt action when it appears necessary; and (3) guidelines to determine when an investigation should be broadened beyond the initial complaint to include sampling patient records to identify patterns of care, reviewing office practices and procedures, reviewing performance and discharge data from hospitals and managed care organizations and conducting additional interviews of patients and peers.

Sec. 5. Section 20-8a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) There shall be within the Department of Public Health a Connecticut Medical Examining Board. Said board shall consist of fifteen members appointed by the Governor, subject to the provisions of section 4-9a, as amended, in the manner prescribed for department heads in section 4-7, as follows: Five physicians practicing in the state; one physician who shall be a full-time member of the faculty of The University of Connecticut School of Medicine; one physician who shall be a full-time chief of staff in a general-care hospital in the state; one physician who shall be registered as a supervising physician for one or more physician assistants; one physician who shall be a graduate of a medical education program accredited by the American Osteopathic Association; one physician assistant licensed pursuant to section 20-12b and practicing in this state; and five public members. No professional member of said board shall be an elected or appointed officer of a professional society or association relating to such member's profession at the time of appointment to the board or have been such an officer during the year immediately preceding appointment or serve for more than two consecutive terms. Professional members shall be practitioners in good professional standing and residents of this state.

(b) All vacancies shall be filled by the Governor in the manner prescribed for department heads in section 4-7. Successors and appointments to fill a vacancy shall fulfill the same qualifications as the member succeeded or replaced. In addition to the requirements in

sections 4-9a, as amended, and 19a-8, no person whose spouse, parent, brother, sister, child or spouse of a child is a physician, as defined in section 20-13a, or a physician assistant, as defined in section 20-12a, shall be appointed as a public member.

(c) The Commissioner of Public Health shall establish a list of eighteen persons who may serve as members of medical hearing panels established pursuant to [subsection (g) of] this section. Persons appointed to the list shall serve as members of the medical hearing panels and provide the same services as members of the Connecticut Medical Examining Board. Members from the list serving on such panels shall not be voting members of the Connecticut Medical Examining Board. The list shall consist of eighteen members appointed by the commissioner, eight of whom shall be physicians, as defined in section 20-13a, with at least one of such physicians being a graduate of a medical education program accredited by the American Osteopathic Association, one of whom shall be a physician assistant licensed pursuant to section 20-12b, and nine of whom shall be members of the public. No professional member of the list shall be an elected or appointed officer of a professional society or association relating to such member's profession at the time of appointment to the list or have been such an officer during the year immediately preceding such appointment to the list. A licensed professional appointed to the list shall be a practitioner in good professional standing and a resident of this state. All vacancies shall be filled by the commissioner. Successors and appointments to fill a vacancy on the list shall possess the same qualifications as those required of the member succeeded or replaced. No person whose spouse, parent, brother, sister, child or spouse of a child is a physician, as defined in section 20-13a, or a physician assistant, as defined in section 20-12a, shall be appointed to the list as a member of the public. Each person appointed to the list shall serve without compensation at the pleasure of the commissioner. Each medical hearing panel shall consist of three members, at least one of whom shall be a member of the Connecticut Medical Examining Board and one of whom shall be a member of the public. The public member may be a member of the board or a member from the list established

pursuant to this subsection.

(d) The office of the board shall be in Hartford, in facilities to be provided by the department.

(e) The board shall adopt and may amend a seal.

(f) The Governor shall appoint a chairperson from among the board members. Said board shall meet at least once during each calendar quarter and at such other times as the chairperson deems necessary. Special meetings shall be held on the request of a majority of the board after notice in accordance with the provisions of section 1-225. A majority of the members of the board shall constitute a quorum. Members shall not be compensated for their services. Any member who fails to attend three consecutive meetings or who fails to attend fifty per cent of all meetings held during any calendar year shall be deemed to have resigned from office. Minutes of all meetings shall be recorded by the board. No member shall participate in the affairs of the board during the pendency of any disciplinary proceedings by the board against such member. Said board shall (1) hear and decide matters concerning suspension or revocation of licensure, (2) adjudicate complaints against practitioners, and (3) impose sanctions where appropriate.

(g) (1) Not later than December 31, 2004, the board, with the assistance of the department, shall adopt regulations, in accordance with chapter 54, to establish guidelines for use in the disciplinary process. Such guidelines shall include, but need not be limited to: (A) Identification of each type of violation; (B) a minimum and maximum penalty for each type of violation; (C) additional optional conditions that may be imposed by the board for each violation; (D) identification of factors the board shall consider in determining if the maximum or minimum penalty should apply; (E) conditions, such as mitigating factors or other facts, that may be considered in allowing deviations from the guidelines; and (F) a provision that when a deviation from the guidelines occurs, the reason for the deviation shall be identified.

(2) The board shall refer all statements of charges filed with the board by the department pursuant to section 20-13e, as amended by this act, to a medical hearing panel [within] not later than sixty days [of] after the receipt of charges. [This] The time period may be extended for good cause by the board in a duly recorded vote. [The panel shall consist of three members, at least one of whom shall be a member of the board and one a member of the public. The public member may be a member of either the board or of the list established pursuant to subsection (c) of this section.] The panel shall conduct a hearing, in accordance with the provisions of chapter 54, and the regulations [established] adopted by the Commissioner of Public Health concerning contested cases, except that the panel shall file a proposed final decision with the board [within] not later than one hundred twenty days [of] after the receipt of the issuance of the notice of hearing by the board. The time period for filing such proposed final decision with the board may be extended for good cause by the board in a duly recorded vote. If the panel does not conduct a hearing within sixty days of the date of referral of the statement of charges by the board, the commissioner shall conduct a hearing in accordance with chapter 54 and the regulations adopted by the commissioner concerning contested cases. The commissioner shall file a proposed final decision with the board not later than sixty days after such hearing, except that the time period for filing such proposed final decision with the board may be extended for good cause by the board in a duly recorded vote.

(3) The board shall refer all findings of no probable cause filed with the board by the department pursuant to section 20-13e, as amended by this act, to a medical hearing panel not later than sixty days after the receipt of charges. The time period may be extended for good cause by the board in a duly recorded vote. The panel shall review the petition and the entire record of the investigation and may ask the department for more information or for a reconsideration of such finding. If the panel takes no action within ninety days of the submission to the board of such finding, the department's finding of no probable cause shall be considered final.

(h) The board shall review the panel's proposed final decision in accordance with the provisions of section 4-179, and adopt, modify or remand said decision for further review or for the taking of additional evidence. The board shall act on the proposed final decision within ninety days of the filing of said decision by the panel. **[**This**]** The time period may be extended by the board for good cause in a duly recorded vote.

(i) Except in a case in which a license has been summarily suspended, pursuant to subsection (c) of section 19a-17 or subsection (c) of section 4-182, all three panel members shall be present to hear any evidence and vote on a proposed final decision. The chairperson of the Medical Examining Board may exempt a member from a meeting of the panel if the chairperson finds that good cause exists for such an exemption. Such an exemption may be granted orally but shall be reduced to writing and included as part of the record of the panel within two business days of the granting of the exemption or the opening of the record and shall state the reason for the exemption. Such exemption shall be granted to a member no more than once during any contested case and shall not be granted for a meeting at which the panel is acting on a proposed final decision on a statement of charges. The board may appoint a member to the panel to replace any member who resigns or otherwise fails to continue to serve on the panel. Such replacement member shall review the record prior to the next hearing.

(j) A determination of good cause shall not be reviewable and shall not constitute a basis for appeal of the decision of the board pursuant to section 4-183.

Sec. 6. Section 20-13i of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

The department shall file with the Governor and the joint standing committee on public health of the General Assembly on or before January 1, 1986, and thereafter on or before January first of each succeeding year, a report of the activities of the department and the

board conducted pursuant to sections 20-13d and 20-13e, as amended by this act. Each such report shall include, but shall not be limited to, the following information: The number of petitions received; the number of petitions not investigated, and the reasons why; the number of hearings held on such petitions; **[**and,**]** the outcome of such hearings; the timeliness of action taken on any petition considered to be a priority; without identifying the particular physician concerned, a brief description of the impairment alleged in each such petition and the actions taken with regard to each such petition by the department and the board; the number of notifications received pursuant to section 19a-17a, as amended by this act; the number of such notifications with no further action taken, and the reasons why; and the outcomes for notifications where further action is taken.

Sec. 7. (NEW) (*Effective from passage*) (a) Each licensed hospital or outpatient surgical facility shall establish protocols for screening patients prior to any surgery. Such protocols shall require that: (1) Prior to any surgery the principal surgeon and four other persons employed by or associated with the hospital or facility (A) identify the patient and, if the patient is able to do so, have the patient identify himself or herself, and (B) identify the procedure to be performed, and (2) no patient may be anesthetized and no surgery may be performed unless the identifications specified in subdivision (1) of this subsection have been confirmed by all such persons, except that such protocols may provide for alternative identification procedures where the patient is unconscious or under emergency circumstances. Each licensed hospital or outpatient surgical facility shall annually submit to the Department of Public Health a copy of such protocols and a report on their implementation.

(b) The Department of Public Health shall assist each hospital or outpatient surgical facility with the development and implementation of the screening protocols required under subsection (a) of this section.

Sec. 8. Section 52-192a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) After commencement of any civil action based upon contract or seeking the recovery of money damages, whether or not other relief is sought, the plaintiff may, not later than thirty days before trial, file with the clerk of the court a written "offer of judgment" signed by the plaintiff or the plaintiff's attorney, directed to the defendant or the defendant's attorney, offering to settle the claim underlying the action and to stipulate to a judgment for a sum certain. The plaintiff shall give notice of the offer of settlement to the defendant's attorney or, if the defendant is not represented by an attorney, to the defendant himself or herself. Within sixty days after being notified of the filing of the "offer of judgment" or within any extension or extensions thereof, not to exceed a total of one hundred twenty additional days, granted by the court for good cause shown, and prior to the rendering of a verdict by the jury or an award by the court, the defendant or the defendant's attorney may file with the clerk of the court a written "acceptance of offer of judgment" agreeing to a stipulation for judgment as contained in plaintiff's "offer of judgment". Upon such filing, the clerk shall enter judgment immediately on the stipulation. If the "offer of judgment" is not accepted within [sixty days] the sixty-day period or any extension thereof, and prior to the rendering of a verdict by the jury or an award by the court, the "offer of judgment" shall be considered rejected and not subject to acceptance unless refiled. Any such "offer of judgment" and any "acceptance of offer of judgment" shall be included by the clerk in the record of the case.

(b) After trial the court shall examine the record to determine whether the plaintiff made an "offer of judgment" which the defendant failed to accept. If the cause of action accrued prior to the effective date of this section and the court ascertains from the record that the plaintiff has recovered an amount equal to or greater than the sum certain stated in the plaintiff's "offer of judgment", the court shall add to the amount so recovered twelve per cent annual interest on said amount. [, computed from the date such offer was filed in actions commenced before October 1, 1981. In those actions commenced on or after October 1, 1981, the] If the cause of action accrued on or after the effective date of this section and the court ascertains from the record that the plaintiff

has recovered an amount equal to or greater than the sum certain stated in the plaintiff's offer of judgment, the court shall add to the amount so recovered twelve per cent annual interest on said amount, except that if the plaintiff has recovered an amount that is more than twice the sum certain stated in the plaintiff's offer of judgment, the court shall add to the amount so recovered (1) twelve per cent annual interest on the portion of the amount recovered that is equal to or less than twice the sum certain stated in such offer of judgment, and (2) six per cent annual interest on the portion of the amount recovered that is more than twice the sum certain stated in such offer. The interest shall be computed from the date the complaint in the civil action was filed with the court if the "offer of judgment" was filed not later than eighteen months from the filing of such complaint. If such offer was filed later than eighteen months from the date of filing of the complaint, the interest shall be computed from the date the "offer of judgment" was filed. The court may award reasonable attorney's fees in an amount not to exceed three hundred fifty dollars, and shall render judgment accordingly. This section shall not be interpreted to abrogate the contractual rights of any party concerning the recovery of attorney's fees in accordance with the provisions of any written contract between the parties to the action.

Sec. 9. Subsection (a) of section 20-13e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) (1) The department shall investigate each petition filed pursuant to section 20-13d, in accordance with the provisions of subdivision (10) of subsection (a) of section 19a-14, to determine if probable cause exists to issue a statement of charges and to institute proceedings against the physician under subsection (e) of this section. Such investigation shall be concluded not later than eighteen months from the date the petition is filed with the department and, unless otherwise specified by this subsection, the record of such investigation shall be deemed a public record, in accordance with section 1-210, as amended, at the conclusion of such eighteen-month period. Any such investigation shall be

confidential and no person shall disclose his knowledge of such investigation to a third party unless the physician requests that such investigation and disclosure be open. If the department determines that probable cause exists to issue a statement of charges, the entire record of such proceeding shall be public unless the department determines that the physician is an appropriate candidate for participation in a rehabilitation program in accordance with subsection (b) of this section and the physician agrees to participate in such program in accordance with terms agreed upon by the department and the physician. If at any time subsequent to the filing of a petition and during the eighteen-month period, the department makes a finding of no probable cause and the medical panel appointed pursuant to section 20-8a, as amended by this act, allows such finding to stand, the petition and the entire record of such investigation shall remain confidential unless the physician requests that such petition and record be open.

(2) If the department makes a finding of no probable cause, it shall notify the person who filed the petition or such person's legal representative of such finding and the reasons therefor.

Sec. 10. Subsection (b) of section 19a-88 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) Each person holding a license to practice medicine, surgery, podiatry, chiropractic or natureopathy shall, annually, during the month of such person's birth, register with the Department of Public Health, upon payment of the professional services fee for class I, as defined in section 33-182l, on blanks to be furnished by the department for such purpose, giving such person's name in full, such person's residence and business address, the name of the insurance company providing such person's professional liability insurance and the policy number of such insurance, such person's area of specialization, whether such person is actively involved in patient care, any disciplinary action against such person, or malpractice payments made

on behalf of such person in any other state or jurisdiction, and such other information as the department requests. The department may compare information submitted pursuant to this subsection to information contained in the National Practitioner Data Base.

Sec. 11. (NEW) (*Effective from passage*) On or before January 1, 2005, and annually thereafter, the Department of Public Health shall report, in accordance with section 11-4a of the general statutes, the number of physicians by specialty who are actively providing patient care.

Sec. 12. (NEW) (*Effective July 1, 2004*) Each insurer that delivers, issues for delivery or renews in this state a professional liability insurance policy for a medical professional or entity shall offer a premium discount on the policy to any insured who submits to the insurer proof that the insured will use an electronic health record system during the premium period to establish and maintain patient records and verify patient treatment. Such discount shall be not less than ten per cent of the premium for a period of one year from the effective date of the policy or renewal.

Sec. 13. (NEW) (*Effective July 1, 2004*) The Connecticut Health and Educational Facilities Authority shall establish a program, within available appropriations, to finance grants to hospitals to install or upgrade electronic health record systems for the establishment and maintenance of patient records and verification of patient treatment. The program shall be known as the Connecticut Electronic Health Records Program. Grants shall be made for the purpose of establishing or upgrading electronic health record systems for use by hospitals in order to promote patient safety and eliminate errors.

Sec. 14. Section 38a-676 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) With respect to rates pertaining to commercial risk insurance, and subject to the provisions of subsection (b) of this section with respect to workers' compensation and employers' liability insurance and certain professional liability insurance, on or before the effective

date [thereof, every] of such rates, each admitted insurer shall submit to the Insurance Commissioner for the commissioner's information, except as to inland marine risks which by general custom of the business are not written according to manual rates or rating plans, [every] each manual of classifications, rules and rates, and [every] each minimum, class rate, rating plan, rating schedule and rating system and any modification of the foregoing which it uses. Such submission by a licensed rating organization of which an insurer is a member or subscriber shall be sufficient compliance with this section for any insurer maintaining membership or subscribership in such organization, to the extent that the insurer uses the manuals, minimums, class rates, rating plans, rating schedules, rating systems, policy or bond forms of such organization. The information shall be open to public inspection after its submission.

(b) (1) Each filing as described in subsection (a) of this section for workers' compensation or employers' liability insurance shall be on file with the Insurance Commissioner for a waiting period of thirty days before it becomes effective, which period may be extended by the commissioner for an additional period not to exceed thirty days if the commissioner gives written notice within such waiting period to the insurer or rating organization which made the filing that the commissioner needs such additional time for the consideration of such filing. Upon written application by such insurer or rating organization, the commissioner may authorize a filing which the commissioner has reviewed to become effective before the expiration of the waiting period or any extension thereof. A filing shall be deemed to meet the requirements of sections 38a-663 to 38a-696, inclusive, unless disapproved by the commissioner within the waiting period or any extension thereof. If, within the waiting period or any extension thereof, the commissioner finds that a filing does not meet the requirements of said sections, the commissioner shall send to the insurer or rating organization which made such filing written notice of disapproval of such filing, specifying therein in what respects the commissioner finds such filing fails to meet the requirements of said

sections and stating that such filing shall not become effective. Such finding of the commissioner shall be subject to review as provided in section 38a-19.

(2) Each filing as described in subsection (a) of this section for professional liability insurance for physicians and surgeons, hospitals or advanced practice registered nurses shall be subject to prior rate approval in accordance with this section. On and after the effective date of this section, each insurer or rating organization seeking to change its rates for such insurance shall (A) file a request for such change with the Insurance Department, and (B) provide written notice to its insureds with respect to any request for an increase in rates. Such request shall be filed and such notice, if applicable, shall be sent at least sixty days prior to the proposed effective date of the change. The notice to insureds of a request for an increase in rates shall indicate that a public hearing shall be held in accordance with this section. The Insurance Department shall review the request and, with respect to a request for an increase in rates, shall hold a public hearing on such increase prior to approving or denying the request. The Insurance Commissioner shall approve or deny the request not later than forty-five days after its receipt. Such finding of the commissioner shall be subject to review as provided in section 38a-19.

(c) The form of any insurance policy or contract the rates for which are subject to the provisions of sections 38a-663 to 38a-696, inclusive, other than fidelity, surety or guaranty bonds, and the form of any endorsement modifying such insurance policy or contract, shall be filed with the Insurance Commissioner prior to its issuance. The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, establishing a procedure for review of such policy or contract. If at any time the commissioner finds that any such policy, contract or endorsement is not in accordance with such provisions or any other provision of law, the commissioner shall issue an order disapproving the issuance of such form and stating the reasons for disapproval. The provisions of section 38a-19 shall apply to any such order issued by the commissioner.

Sec. 15. (NEW) (*Effective October 1, 2004*) (a) On and after October 1, 2004, no captive insurer, as defined in section 38a-91 of the general statutes, may insure a health care provider or entity in this state against liability for medical malpractice unless the captive insurer has obtained a certificate of authority from the Insurance Commissioner, except that no certificate of authority shall be required for any captive insurer that is duly licensed in this state to offer such insurance.

(b) Any captive insurer seeking to obtain a certificate of authority shall make application to the commissioner, on such form as the commissioner requires, setting forth the line or lines of business which it is seeking authorization to write. The captive insurer shall file with the commissioner a certified copy of its charter or articles of association and evidence satisfactory to the commissioner that it has complied with the laws of the jurisdiction under which it is organized, a statement of its financial condition in such form as is required by the commissioner, together with such evidence of its correctness as the commissioner requires and evidence of good management in such form as is required by the commissioner. The captive insurer shall submit evidence of its ability to provide continuous and timely claims settlement. If the information furnished is satisfactory to the commissioner, and if all other requirements of law have been complied with, the commissioner may issue to such insurer a certificate of authority permitting it to do business in this state. Each such certificate of authority shall expire on the first day of May succeeding the date of its issuance, but may be renewed without any formalities except as required by the commissioner. Failure of a captive insurer to exercise its authority to write a particular line or lines of business in this state for two consecutive calendar years may constitute sufficient cause for revocation of the captive insurer's authority to write those lines of business.

(c) The commissioner shall adopt regulations, in accordance with chapter 54 of the general statutes, specifying the information and evidence that a captive insurer seeking to obtain or renew a certificate of authority shall submit and the requirements with which it shall

comply.

(d) The commissioner may, at any time, for cause, suspend, revoke or refuse to renew any such certificate of authority or in lieu of or in addition to suspension or revocation of such certificate of authority the commissioner, after reasonable notice to and hearing of any holder of such certificate of authority, may impose a fine not to exceed ten thousand dollars. Such hearings may be held by the commissioner or any person designated by the commissioner. Whenever a person other than the commissioner acts as the hearing officer, the person shall submit to the commissioner a memorandum of findings and recommendations upon which the commissioner may base a decision. The commissioner may, if the commissioner deems it in the interest of the public, publish in one or more newspapers of the state a statement that, under the provisions of this section, the commissioner has suspended or revoked the certificate of authority of any captive insurer to do business in this state.

(e) Each application for a certificate of authority shall be accompanied by a nonrefundable fee as set forth in section 38a-11 of the general statutes, as amended by this act. All expenses incurred by the commissioner in connection with proceedings under this section shall be paid by the person filing the application.

(f) Any captive insurer aggrieved by the action of the commissioner in revoking, suspending or refusing to renew a certificate of authority or in imposing a fine may appeal therefrom, in accordance with the provisions of section 4-183 of the general statutes, except venue for such appeal shall be in the judicial district of New Britain. Appeals under this section shall be privileged in respect to the order of trial assignment.

Sec. 16. Subsection (a) of section 38a-11 of the general statutes, as amended by section 10 of public act 03-152 and section 9 of public act 03-169, is repealed and the following is substituted in lieu thereof (*Effective October 1, 2004*):

(a) The commissioner shall demand and receive the following fees: (1) For the annual fee for each license issued to a domestic insurance company, one hundred dollars; (2) for receiving and filing annual reports of domestic insurance companies, twenty-five dollars; (3) for filing all documents prerequisite to the issuance of a license to an insurance company, one hundred seventy-five dollars, except that the fee for such filings by any health care center, as defined in section 38a-175, shall be one thousand one hundred dollars; (4) for filing any additional paper required by law, fifteen dollars; (5) for each certificate of valuation, organization, reciprocity or compliance, twenty dollars; (6) for each certified copy of a license to a company, twenty dollars; (7) for each certified copy of a report or certificate of condition of a company to be filed in any other state, twenty dollars; (8) for amending a certificate of authority, one hundred dollars; (9) for each license issued to a rating organization, one hundred dollars. In addition, insurance companies shall pay any fees imposed under section 12-211; (10) a filing fee of twenty-five dollars for each initial application for a license made pursuant to section 38a-769; (11) with respect to insurance agents' appointments: (A) A filing fee of twenty-five dollars for each request for any agent appointment; (B) a fee of forty dollars for each appointment issued to an agent of a domestic insurance company or for each appointment continued; and (C) a fee of twenty dollars for each appointment issued to an agent of any other insurance company or for each appointment continued, except that no fee shall be payable for an appointment issued to an agent of an insurance company domiciled in a state or foreign country which does not require any fee for an appointment issued to an agent of a Connecticut insurance company; (12) with respect to insurance producers: (A) An examination fee of seven dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of seven dollars to the commissioner for each examination taken by an applicant; (B) a fee of forty dollars for each license issued; and (C) a fee of forty dollars for each license renewed; (13) with respect to public adjusters: (A) An examination fee of seven dollars for each examination taken, except when a testing service is

used, the testing service shall pay a fee of seven dollars to the commissioner for each examination taken by an applicant; and (B) a fee of one hundred twenty-five dollars for each license issued or renewed; (14) with respect to casualty adjusters: (A) An examination fee of ten dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of ten dollars to the commissioner for each examination taken by an applicant; (B) a fee of forty dollars for each license issued or renewed; and (C) the expense of any examination administered outside the state shall be the responsibility of the entity making the request and such entity shall pay to the commissioner one hundred dollars for such examination and the actual traveling expenses of the examination administrator to administer such examination; (15) with respect to motor vehicle physical damage appraisers: (A) An examination fee of forty dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of forty dollars to the commissioner for each examination taken by an applicant; (B) a fee of forty dollars for each license issued or renewed; and (C) the expense of any examination administered outside the state shall be the responsibility of the entity making the request and such entity shall pay to the commissioner one hundred dollars for such examination and the actual traveling expenses of the examination administrator to administer such examination; (16) with respect to certified insurance consultants: (A) An examination fee of thirteen dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of thirteen dollars to the commissioner for each examination taken by an applicant; (B) a fee of two hundred dollars for each license issued; and (C) a fee of one hundred twenty-five dollars for each license renewed; (17) with respect to surplus lines brokers: (A) An examination fee of ten dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of ten dollars to the commissioner for each examination taken by an applicant; and (B) a fee of five hundred dollars for each license issued or renewed; (18) with respect to fraternal agents, a fee of forty dollars for each license issued or renewed; (19) a fee of thirteen dollars for

each license certificate requested, whether or not a license has been issued; (20) with respect to domestic and foreign benefit societies shall pay: (A) For service of process, twenty-five dollars for each person or insurer to be served; (B) for filing a certified copy of its charter or articles of association, five dollars; (C) for filing the annual report, ten dollars; and (D) for filing any additional paper required by law, three dollars; (21) with respect to foreign benefit societies: (A) For each certificate of organization or compliance, four dollars; (B) for each certified copy of permit, two dollars; and (C) for each copy of a report or certificate of condition of a society to be filed in any other state, four dollars; (22) with respect to reinsurance intermediaries: A fee of five hundred dollars for each license issued or renewed; (23) with respect to viatical settlement providers: (A) A filing fee of thirteen dollars for each initial application for a license made pursuant to section 38a-465a, as amended; and (B) a fee of twenty dollars for each license issued or renewed; (24) with respect to viatical settlement brokers: (A) A filing fee of thirteen dollars for each initial application for a license made pursuant to section 38a-465a, as amended; and (B) a fee of twenty dollars for each license issued or renewed; (25) with respect to viatical settlement investment agents: (A) A filing fee of thirteen dollars for each initial application for a license made pursuant to section 38a-465a, as amended; and (B) a fee of twenty dollars for each license issued or renewed; (26) with respect to preferred provider networks, a fee of two thousand five hundred dollars for each license issued or renewed; (27) with respect to rental companies, as defined in section 38a-799, a fee of forty dollars for each permit issued or renewed; (28) with respect to a certificate of authority for a captive insurer pursuant to section 15 of this act, a fee of one hundred seventy-five dollars for each certificate issued or renewed; and **[**(28)**]** (29) with respect to each duplicate license issued a fee of twenty-five dollars for each license issued.

Sec. 17. Section 52-251c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage and applicable to causes of action accruing on or after said date*):

(a) In any claim or civil action to recover damages resulting from

personal injury, wrongful death or damage to property occurring on or after October 1, 1987, the attorney and the claimant may provide by contract, which contract shall comply with all applicable provisions of the rules of professional conduct governing attorneys adopted by the judges of the Superior Court, that the fee for the attorney shall be paid contingent upon, and as a percentage of: (1) Damages awarded and received by the claimant; or (2) settlement amount pursuant to a settlement agreement.

(b) In any such contingency fee arrangement such fee shall be the exclusive method for payment of the attorney by the claimant and shall not exceed an amount equal to a percentage of the damages awarded and received by the claimant or of the settlement amount received by the claimant as follows: (1) Thirty-three and one-third per cent of the first three hundred thousand dollars; (2) twenty-five per cent of the next three hundred thousand dollars; (3) twenty per cent of the next three hundred thousand dollars; (4) fifteen per cent of the next three hundred thousand dollars; and (5) ten per cent of any amount which exceeds one million two hundred thousand dollars.

(c) Whenever a claimant in a medical malpractice case enters into a contingency fee arrangement with an attorney which provides for a fee that would exceed the percentage limitations set forth in subsection (b) of this section, such arrangement shall not be valid unless the claimant's attorney files an application with the court for approval of such arrangement and the court, after a hearing, grants such application. The claimant's attorney shall attach to such application a copy of such fee arrangement and the proposed unsigned writ, summons and complaint in the case. Such fee arrangement shall provide that the attorney will advance all costs in connection with the investigation and prosecution or settlement of the case and the claimant will not be liable for the reimbursement of the attorney for any such costs if there is no recovery. The court shall grant such application if it finds that the case is sufficiently complex, unique or different from other medical malpractice cases so as to warrant a deviation from such percentage limitations. At the hearing, the

claimant's attorney shall have the burden of showing that such deviation is warranted. In no event shall the court grant an application approving a fee arrangement that provides for a fee that exceeds an amount equal to thirty-three and one-third per cent of the damages awarded and received by the claimant or of the settlement amount received by the claimant. If the court denies the application, the court shall advise the claimant of the claimant's right to seek representation by another attorney willing to abide by the percentage limitations set forth in subsection (b) of this section. The decision of the court to grant or deny the application shall not be subject to appeal. The filing of such application shall toll the applicable statute of limitations until ninety days after the court's decision to grant or deny the application. The Chief Court Administrator shall assign a judge or judges with experience in personal injury cases to hear and determine applications filed under this subsection.

(d) If the attorney makes disbursements or incurs costs in connection with the investigation and prosecution or settlement of the claim or civil action for which the claimant is liable, in no event shall the claimant be required to pay interest on the amount of such disbursements and costs.

[(c)**]** (e) For the purposes of this section, "damages awarded and received" means in a civil action in which final judgment is entered, that amount of the judgment or amended judgment entered by the court that is received by the claimant **[**, except that in a civil action brought pursuant to section 38a-368 such amount shall be reduced by any basic reparations benefits paid to the claimant pursuant to section 38a-365;**]** after deduction for any disbursements made or costs incurred by the attorney in connection with the investigation and prosecution or settlement of the civil action, other than ordinary office overhead and expense, for which the claimant is liable; and "settlement amount received" means in a claim or civil action in which no final judgment is entered, the amount received by the claimant pursuant to a settlement agreement **[**, except that in a claim or civil action brought pursuant to section 38a-368 such amount shall be reduced by any basic reparations

benefits paid to the claimant pursuant to section 38a-365; and "fee" shall not include disbursements or costs incurred in connection with the prosecution or settlement of the claim or civil action, other than ordinary office overhead and expense**]** after deduction for any disbursements made or costs incurred by the attorney in connection with the investigation and prosecution or settlement of the claim or civil action, other than ordinary office overhead and expense, for which the claimant is liable.

Sec. 18. Section 38a-395 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2005*):

[The Insurance Commissioner may require all insurance companies writing medical malpractice insurance in this state to submit, in such manner and at such times as he specifies, such information as he deems necessary to establish a data base on medical malpractice, including information on all incidents of medical malpractice, all settlements, all awards, other information relative to procedures and specialties involved and any other information relating to risk management.**]**

(a) As used in this section:

(1) "Claim" means a request for indemnification filed by a medical professional or entity pursuant to a professional liability policy for a loss for which a reserve amount has been established by an insurer;

(2) "Closed claim" means a claim that has been settled, or otherwise disposed of, where the insurer has made all indemnity and expense payments on the claim; and

(3) "Insurer" means an insurer, as defined in section 38a-1, as amended, that insures a medical professional or entity against professional liability. "Insurer" includes, but is not limited to, a captive insurer or a self-insured person.

(b) On and after January 1, 2005, each insurer shall provide to the Insurance Commissioner a closed claim report, on such form as the

commissioner prescribes, in accordance with this section. The insurer shall submit the report not later than ten days after the last day of the calendar quarter in which a claim is closed. The report shall only include information about claims settled under the laws of this state.

(c) The closed claim report shall include:

(1) Details about the insured and insurer, including: (A) The name of the insurer; (B) the professional liability insurance policy limits and whether the policy was an occurrence policy or was issued on a claims-made basis; (C) the name, address, health care provider professional license number and specialty coverage of the insured; and (D) the insured's policy number and a unique claim number.

(2) Details about the injury or loss, including: (A) The date of the injury or loss that was the basis of the claim; (B) the date the injury or loss was reported to the insurer; (C) the name of the institution or location at which the injury or loss occurred; (D) the type of injury or loss, including a severity of injury rating that corresponds with the severity of injury scale that the Insurance Commissioner shall establish based on the severity of injury scale developed by the National Association of Insurance Commissioners; and (E) the name, age and gender of any injured person covered by the claim. Any individually identifiable information submitted pursuant to this subdivision shall be confidential.

(3) Details about the claims process, including: (A) Whether a lawsuit was filed, and if so, in which court; (B) the outcome of such lawsuit; (C) the number of other defendants, if any; (D) the stage in the process when the claim was closed; (E) the dates of the trial; (F) the date of the judgment or settlement, if any; (G) whether an appeal was filed, and if so, the date filed; (H) the resolution of the appeal and the date such appeal was decided; (I) the date the claim was closed; (J) the initial indemnity and expense reserve for the claim; and (K) the final indemnity and expense reserve for the claim.

(4) Details about the amount paid on the claim, including: (A) The

total amount of the initial judgment rendered by a jury or awarded by the court; (B) the total amount of the settlement if there was no judgment rendered or awarded; (C) the total amount of the settlement if the claim was settled after judgment was rendered or awarded; (D) the amount of economic damages, as defined in section 52-572h, or the insurer's estimate of the amount in the event of a settlement; (E) the amount of noneconomic damages, as defined in section 52-572h, or the insurer's estimate of the amount in the event of a settlement; (F) the amount of any interest awarded due to failure to accept an offer of judgment; (G) the amount of any remittitur or additur; (H) the amount of final judgment after remittitur or additur; (I) the amount paid by the insurer; (J) the amount paid by the defendant due to a deductible or a judgment or settlement in excess of policy limits; (K) the amount paid by other insurers; (L) the amount paid by other defendants; (M) whether a structured settlement was used; (N) the expense assigned to and recorded with the claim, including, but not limited to, defense and investigation costs, but not including the actual claim payment; and (O) any other information the commissioner determines to be necessary to regulate the professional liability insurance industry with respect to medical professionals and entities, ensure the industry's solvency and ensure that such liability insurance is available and affordable.

(d) (1) The commissioner shall establish an electronic database composed of closed claim reports filed pursuant to this section.

(2) The commissioner shall compile the data included in individual closed claim reports into an aggregated summary format and shall prepare a written annual report of the summary data. The report shall provide an analysis of closed claim information including a minimum of five years of comparative data, when available, trends in frequency and severity of claims, itemization of damages, timeliness of the claims process, and any other descriptive or analytical information that would assist in interpreting the trends in closed claims.

(3) The annual report shall include a summary of rate filings for

professional liability insurance for medical professionals and entities which have been approved by the department for the prior calendar year, including an analysis of the trend of direct losses, incurred losses, earned premiums and investment income as compared to prior years. The report shall include base premiums charged by medical malpractice insurers for each specialty and the number of providers insured by specialty for each insurer.

(4) Not later than March 15, 2006, and annually thereafter, the commissioner shall submit the annual report to the joint standing committee of the General Assembly having cognizance of matters relating to insurance in accordance with section 11-4a. The commissioner shall also (A) make the report available to the public, (B) post the report on its Internet site, and (C) provide public access to the contents of the electronic database after the commissioner establishes that the names and other individually identifiable information about the claimant and practitioner have been removed.

(e) The Insurance Commissioner shall provide the Commissioner of Public Health with electronic access to all information received pursuant to this section.

Sec. 19. (NEW) (*Effective from passage*) (a) The Commissioner of Public Health shall designate a patient safety ombudsman within the Department of Public Health to improve patient safety and reduce medical errors by coordinating state initiatives on patient safety, facilitating ongoing collaborations between the public and private sectors, and promoting patient safety through education of health care providers and patients.

(b) The duties of the patient safety ombudsman shall be to: (1) Establish a Patient Safety and Medical Errors Program; (2) create an education and research program for the health care industry and the public on issues relating to the causes and consequences of medical errors; (3) establish a clearinghouse for reporting on best practices that improve patient safety; (4) coordinate data collection and analysis, in conjunction with other offices in the Department of Public Health, to

develop programs that promote patient safety; (5) coordinate state and federal patient safety programs; and (6) participate in the federal Patient Safety Improvement Corps to identify the causes of medical errors.

(c) On or before January 1, 2005, and annually thereafter, the patient safety ombudsman shall submit a report, in accordance with the provisions of section 11-4a of the general statutes, to the Governor and the chairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to public health, describing the progress in completing his or her duties, a description of activities undertaken, the groups and number of persons served and recommendations for future action.

Sec. 20. (NEW) (*Effective from passage*) Whenever in a civil action to recover damages resulting from personal injury or wrongful death, whether in tort or in contract, in which it is alleged that such injury or death resulted from the negligence of a health care provider, the jury renders a verdict specifying noneconomic damages, as defined in section 52-572h of the general statutes, in an amount exceeding one million dollars, the court shall review the evidence presented to the jury to determine if the amount of noneconomic damages specified in the verdict is excessive as a matter of law in that it so shocks the sense of justice as to compel the conclusion that the jury was influenced by partiality, prejudice, mistake or corruption. If the court so concludes, it shall order a remittitur and, upon failure of the party so ordered to remit the amount ordered by the court, it shall set aside the verdict and order a new trial.

Sec. 21. Subdivision (20) of subsection (a) of section 12-701 of the general statutes, as amended by section 13 of public act 03-225, is repealed and the following is substituted in lieu thereof (*Effective from passage and applicable to taxable years commencing on or after January 1, 2004*):

(20) "Connecticut adjusted gross income" means adjusted gross income, with the following modifications:

(A) There shall be added thereto (i) to the extent not properly includable in gross income for federal income tax purposes, any interest income from obligations issued by or on behalf of any state, political subdivision thereof, or public instrumentality, state or local authority, district or similar public entity, exclusive of such income from obligations issued by or on behalf of the state of Connecticut, any political subdivision thereof, or public instrumentality, state or local authority, district or similar public entity created under the laws of the state of Connecticut and exclusive of any such income with respect to which taxation by any state is prohibited by federal law, (ii) any exempt-interest dividends, as defined in Section 852(b)(5) of the Internal Revenue Code, exclusive of such exempt-interest dividends derived from obligations issued by or on behalf of the state of Connecticut, any political subdivision thereof, or public instrumentality, state or local authority, district or similar public entity created under the laws of the state of Connecticut and exclusive of such exempt-interest dividends derived from obligations, the income with respect to which taxation by any state is prohibited by federal law, (iii) any interest or dividend income on obligations or securities of any authority, commission or instrumentality of the United States which federal law exempts from federal income tax but does not exempt from state income taxes, (iv) to the extent included in gross income for federal income tax purposes for the taxable year, the total taxable amount of a lump sum distribution for the taxable year deductible from such gross income in calculating federal adjusted gross income, (v) to the extent properly includable in determining the net gain or loss from the sale or other disposition of capital assets for federal income tax purposes, any loss from the sale or exchange of obligations issued by or on behalf of the state of Connecticut, any political subdivision thereof, or public instrumentality, state or local authority, district or similar public entity created under the laws of the state of Connecticut, in the income year such loss was recognized, (vi) to the extent deductible in determining federal adjusted gross income, any income taxes imposed by this state, (vii) to the extent deductible in determining federal adjusted gross income, any interest on

indebtedness incurred or continued to purchase or carry obligations or securities the interest on which is exempt from tax under this chapter, (viii) expenses paid or incurred during the taxable year for the production or collection of income which is exempt from taxation under this chapter or the management, conservation or maintenance of property held for the production of such income, and the amortizable bond premium for the taxable year on any bond the interest on which is exempt from tax under this chapter to the extent that such expenses and premiums are deductible in determining federal adjusted gross income, and (ix) for property placed in service after September 10, 2001, but prior to September 11, 2004, in taxable years ending after September 10, 2001, any additional allowance for depreciation under subsection (k) of Section 168 of the Internal Revenue Code, as provided by Section 101 of the Job Creation and Worker Assistance Act of 2002, to the extent deductible in determining federal adjusted gross income.

(B) There shall be subtracted therefrom (i) to the extent properly includable in gross income for federal income tax purposes, any income with respect to which taxation by any state is prohibited by federal law, (ii) to the extent allowable under section 12-718, exempt dividends paid by a regulated investment company, (iii) the amount of any refund or credit for overpayment of income taxes imposed by this state, or any other state of the United States or a political subdivision thereof, or the District of Columbia, to the extent properly includable in gross income for federal income tax purposes, (iv) to the extent properly includable in gross income for federal income tax purposes and not otherwise subtracted from federal adjusted gross income pursuant to clause (x) of this subparagraph in computing Connecticut adjusted gross income, any tier 1 railroad retirement benefits, (v) to the extent any additional allowance for depreciation under Section 168(k) of the Internal Revenue Code, as provided by Section 101 of the Job Creation and Worker Assistance Act of 2002, for property placed in service after December 31, 2001, but prior to September 10, 2004, was added to federal adjusted gross income pursuant to subparagraph (A) (ix) of this subdivision in computing Connecticut adjusted gross income for a taxable year ending after December 31, 2001, twenty-five

per cent of such additional allowance for depreciation in each of the four succeeding taxable years, (vi) to the extent properly includable in gross income for federal income tax purposes, any interest income from obligations issued by or on behalf of the state of Connecticut, any political subdivision thereof, or public instrumentality, state or local authority, district or similar public entity created under the laws of the state of Connecticut, (vii) to the extent properly includable in determining the net gain or loss from the sale or other disposition of capital assets for federal income tax purposes, any gain from the sale or exchange of obligations issued by or on behalf of the state of Connecticut, any political subdivision thereof, or public instrumentality, state or local authority, district or similar public entity created under the laws of the state of Connecticut, in the income year such gain was recognized, (viii) any interest on indebtedness incurred or continued to purchase or carry obligations or securities the interest on which is subject to tax under this chapter but exempt from federal income tax, to the extent that such interest on indebtedness is not deductible in determining federal adjusted gross income and is attributable to a trade or business carried on by such individual, (ix) ordinary and necessary expenses paid or incurred during the taxable year for the production or collection of income which is subject to taxation under this chapter but exempt from federal income tax, or the management, conservation or maintenance of property held for the production of such income, and the amortizable bond premium for the taxable year on any bond the interest on which is subject to tax under this chapter but exempt from federal income tax, to the extent that such expenses and premiums are not deductible in determining federal adjusted gross income and are attributable to a trade or business carried on by such individual, (x) (I) for a person who files a return under the federal income tax as an unmarried individual whose federal adjusted gross income for such taxable year is less than fifty thousand dollars, or as a married individual filing separately whose federal adjusted gross income for such taxable year is less than fifty thousand dollars, or for a husband and wife who file a return under the federal income tax as married individuals filing jointly whose

federal adjusted gross income for such taxable year is less than sixty thousand dollars or a person who files a return under the federal income tax as a head of household whose federal adjusted gross income for such taxable year is less than sixty thousand dollars, an amount equal to the Social Security benefits includable for federal income tax purposes; and (II) for a person who files a return under the federal income tax as an unmarried individual whose federal adjusted gross income for such taxable year is fifty thousand dollars or more, or as a married individual filing separately whose federal adjusted gross income for such taxable year is fifty thousand dollars or more, or for a husband and wife who file a return under the federal income tax as married individuals filing jointly whose federal adjusted gross income from such taxable year is sixty thousand dollars or more or for a person who files a return under the federal income tax as a head of household whose federal adjusted gross income for such taxable year is sixty thousand dollars or more, an amount equal to the difference between the amount of Social Security benefits includable for federal income tax purposes and the lesser of twenty-five per cent of the Social Security benefits received during the taxable year, or twenty-five per cent of the excess described in Section 86(b)(1) of the Internal Revenue Code, (xi) to the extent properly includable in gross income for federal income tax purposes, any amount rebated to a taxpayer pursuant to section 12-746, (xii) to the extent properly includable in the gross income for federal income tax purposes of a designated beneficiary, any distribution to such beneficiary from any qualified state tuition program, as defined in Section 529(b) of the Internal Revenue Code, established and maintained by this state or any official, agency or instrumentality of the state, (xiii) to the extent properly includable in gross income for federal income tax purposes, the amount of any Holocaust victims' settlement payment received in the taxable year by a Holocaust victim, **[**and**]** (xiv) to the extent properly includable in gross income for federal income tax purposes of an account holder, as defined in section 31-51ww, interest earned on funds deposited in the individual development account, as defined in section 31-51ww, of such account holder, and (xv) for the taxable years commencing

January 1, 2004, January 1, 2005, and January 1, 2006, any amount paid by a physician licensed in this state for premiums on a professional liability insurance policy for risks related to the provision of health care.

(C) With respect to a person who is the beneficiary of a trust or estate, there shall be added or subtracted, as the case may be, from adjusted gross income such person's share, as determined under section 12-714, in the Connecticut fiduciary adjustment.

Sec. 22. Section 4-28e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2004*):

(a) There is created a Tobacco Settlement Fund which shall be a separate nonlapsing fund. Any funds received by the state from the Master Settlement Agreement executed November 23, 1998, shall be deposited into the fund.

(b) (1) The Treasurer is authorized to invest all or any part of the Tobacco Settlement Fund, all or any part of the Tobacco and Health Trust Fund created in section 4-28f, as amended, and all or any part of the Biomedical Research Trust Fund created in section 19a-32c. The interest derived from any such investment shall be credited to the resources of the fund from which the investment was made.

(2) Notwithstanding sections 3-13 to 3-13h, inclusive, the Treasurer shall invest the amounts on deposit in the Tobacco Settlement Fund, the Tobacco and Health Trust Fund and the Biomedical Research Trust Fund in a manner reasonable and appropriate to achieve the objectives of such funds, exercising the discretion and care of a prudent person in similar circumstances with similar objectives. The Treasurer shall give due consideration to rate of return, risk, term or maturity, diversification of the total portfolio within such funds, liquidity, the projected disbursements and expenditures, and the expected payments, deposits, contributions and gifts to be received. The Treasurer shall not be required to invest such funds directly in obligations of the state or any political subdivision of the state or in

any investment or other fund administered by the Treasurer. The assets of such funds shall be continuously invested and reinvested in a manner consistent with the objectives of such funds until disbursed in accordance with this section, section 4-28f, as amended, or section 19a-32c.

(c) (1) For the fiscal year ending June 30, 2001, disbursements from the Tobacco Settlement Fund shall be made as follows: (A) To the General Fund in the amount identified as "Transfer from Tobacco Settlement Fund" in the General Fund revenue schedule adopted by the General Assembly; (B) to the Department of Mental Health and Addiction Services for a grant to the regional action councils in the amount of five hundred thousand dollars; and (C) to the Tobacco and Health Trust Fund in an amount equal to nineteen million five hundred thousand dollars.

(2) For the fiscal year ending June 30, 2002, and each fiscal year thereafter disbursements from the Tobacco Settlement Fund shall be made as follows: (A) To the Tobacco and Health Trust Fund in an amount equal to twelve million dollars; (B) to the Biomedical Research Trust Fund in an amount equal to four million dollars; (C) to the General Fund in the amount identified as "Transfer from Tobacco Settlement Fund" in the General Fund revenue schedule adopted by the General Assembly, which amount shall include, but not be limited to, an amount equal to (i) the total exemptions claimed by physicians for premiums on professional liability insurance policies pursuant to subdivision (20) of subsection (a) of section 12-701, as amended by this act, and (ii) the amount identified in the General Fund revenue schedule as necessary to fund the program for the forgiveness of loans established in section 23 of this act; and (D) any remainder to the Tobacco and Health Trust Fund.

(d) For the fiscal year ending June 30, 2000, five million dollars shall be disbursed from the Tobacco Settlement Fund to a tobacco grant account to be established in the Office of Policy and Management. Such funds shall not lapse on June 30, 2000, and shall continue to be

available for expenditure during the fiscal year ending June 30, 2001.

(e) Tobacco grants shall be made from the account established pursuant to subsection (d) of this section by the Secretary of the Office of Policy and Management in consultation with the speaker of the House of Representatives, the president pro tempore of the Senate, the majority leader of the House of Representatives, the majority leader of the Senate, the minority leader of the House of Representatives, the minority leader of the Senate, and the cochairpersons and ranking members of the joint standing committees of the General Assembly having cognizance of matters relating to public health and appropriations and the budgets of state agencies, or their designees. Such grants shall be used to reduce tobacco abuse through prevention, education, cessation, treatment, enforcement and health needs programs.

Sec. 23. (NEW) (*Effective July 1, 2004*) The Board of Governors of Higher Education, in consultation with the Connecticut Medical Examining Board and the Commissioner of Public Health, shall establish a program for the forgiveness of loans provided by the state to individuals for the purpose of completing medical training in obstetrics or neurosurgery at a medical school in this state accredited by the Liaison Committee on Medical Education or the American Osteopathic Association. An individual shall be eligible for such loan forgiveness if the individual obtains a license as a physician pursuant to chapter 370 of the general statutes and practices in this state as a physician or surgeon in the field of obstetrics or neurosurgery for at least five years. The board of governors, in consultation with the Connecticut Medical Examining Board and the Commissioner of Public Health, shall adopt regulations in accordance with chapter 54 of the general statutes, to establish procedures to administer the program for the forgiveness of loans.

Sec. 24. (NEW) (*Effective July 1, 2004*) The Connecticut Health and Educational Facilities Authority shall establish a pilot program, within available appropriations, to finance and provide grants to nonprofit

hospitals in accordance with this section. The grants shall be used by such hospital to provide medical malpractice indemnity or insurance to physicians and surgeons who enjoy privileges at the hospital. Such indemnity or insurance shall be provided through any risk management program or insurance maintained by the hospital. The pilot program shall be known as the Connecticut Physician Insurance Program. A hospital may apply for a grant on such form as the authority prescribes. Grants provided under the pilot program shall not exceed seven hundred fifty thousand dollars in the aggregate.

Sec. 25. (*Effective from passage*) Sections 38a-32 to 38a-36, inclusive, of the general statutes are repealed.

This act shall take effect as follows:	
Section 1	*from passage*
Sec. 2	*from passage and applicable to actions filed on or after said date*
Sec. 3	*from passage*
Sec. 4	*from passage*
Sec. 5	*from passage*
Sec. 6	*from passage*
Sec. 7	*from passage*
Sec. 8	*from passage*
Sec. 9	*from passage*
Sec. 10	*from passage*
Sec. 11	*from passage*
Sec. 12	*July 1, 2004*
Sec. 13	*July 1, 2004*
Sec. 14	*from passage*
Sec. 15	*October 1, 2004*
Sec. 16	*October 1, 2004*
Sec. 17	*from passage and applicable to causes of action accruing on or after said date*
Sec. 18	*January 1, 2005*
Sec. 19	*from passage*
Sec. 20	*from passage*
Sec. 21	*from passage and applicable to taxable years commencing on or after January 1, 2004*
Sec. 22	*July 1, 2004*

Sec. 23	*July 1, 2004*
Sec. 24	*July 1, 2004*
Sec. 25	*from passage*

Statement of Legislative Commissioners:
In section 3(b)(3), "award" was changed to "award or settlement" for accuracy, in sections 1(b), 5(g) and 14(b)(2), "within" was changed to "not later than" for statutory consistency, in section 4(3), "conducting" was added for purposes of grammar, in section 7(a), "members" was changed to "persons" for accuracy, in section 9(a)(2), the language was rephrased for clarity, and in section 18(b), "claim for recovery under a medical liability policy" was replaced by the defined term "claim" for conciseness.

JUD *Joint Favorable Subst.*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 04$	FY 05$	FY 06$
Public Health, Dept.	GF - Cost	50,500	913,210	821,210
Comptroller Misc. Accounts (Fringe Benefits)	GF - Cost	10,100	158,970	358,010
UConn Health Ctr.	Various - Savings	Potential	Potential	Potential
Insurance Dept.	IF - Revenue Gain	Potential Minimal	Potential Minimal	Potential Minimal
Higher Ed., Dept.	GF - Cost	Minimal	Potential Significant	Potential Significant

Note: GF=General Fund; IF=Insurance Fund

Municipal Impact: None

Explanation

Section 1 requires parties to a civil action involving medical malpractice to engage in mandatory mediation by a judge of the superior court. Such mediation shall not stay or delay the prosecution of the case, and shall be for the specified purposes of: (1) reviewing certificates of good faith; (2) attempting to achieve prompt settlement or resolution of cases; and (3) expediting litigation of cases. To the extent that this new process speeds disposition of medical malpractice cases, a workload reduction to the Civil Division of the Superior Court would result.

Section 2 requires plaintiffs to submit a certificate of good faith for any apportionment complaint related to medical malpractice. This requirement could reduce the scope of some malpractice cases and thereby promote quicker disposition. There is no related fiscal impact.

Implementation of **Sections 3-5 and 9** will result in a significant cost to

the Department of Public Health (DPH). The predominant reason for this is a requirement that the agency review and investigate when warranted all medical malpractice claims filed against a licensed physician, chiropractor, dentist or psychologist. Under current law, the agency reviews about 500 complaints and malpractice payment notices annually. Of these, about fifty percent (or 250) progress to an investigation. Under the bill, an additional 380 – 400 filed claims would require agency review each year, prompting an additional 190 – 200 investigations. The agency's Practitioner Investigations Unit currently has nine investigators.

The department's workload would also be increased to the extent that: (a) filed claims involve cases in which multiple medical practitioners are named, (b) the scope of reviews/investigations is broadened following adoption of regulations, and (c) medical review panels convened by the Connecticut Medical Examining Board (CMEB) ask for reconsideration of findings of no probable cause. (The agency dismisses about 240 cases each year concerning physicians following an investigation.)

Additional work would be associated with: (a) developing regulations, (b) notifying parties who have filed a petition questioning a physician's ability to practice, or the person's legal representative, when the department makes a finding of no probable cause, and (c) developing systems for public access to information received about medical malpractice claims, awards and settlements and reporting on the same to the Public Health and Insurance Committees by July 1, 2004.

The DPH will incur FY 05 costs of $613,340 to comply with **Sections 3-5 and 9.** This reflects the full-year salaries of: one Physician (at $142,000 annually), one Supervising Nurse Consultant (at $77,400 annually), two Health Program Associates (at $55,280 annually), two Nurse Consultants (at $66,640 annually), one Administrative Hearings Officer (at an annual salary of $70,000), one Office Assistant (at an annual salary of $34,870), and one half-time Systems Developer (at

$31,230 annually). Also included are one-time equipment costs of $8,000 and other expenses of $5,000. In FY 06 this cost will decrease to $604,340 as equipment costs will not recur. DPH costs will be supplemented by fringe benefit[1] costs of $121,250 in FY 05 and $274,620 in FY 06. A potential minimal revenue gain would be expected should the enhanced investigation process lead to the collection of additional financial penalties from health care professionals. Since the bill is effective from passage, FY 04 costs of approximately $50,500 (DPH) and $10,100 (fringe benefits) would ensue given June 1, 2004 implementation. No funding has been included within sHB 5033 (the Revised FY 05 Appropriations Act, as favorably reported by the Appropriations Committee) for these purposes.

Section 5 requires the Connecticut Medical Examining Board (CMEB), with the assistance of the DPH, to adopt regulations by December 31, 2004, to establish guidelines for use in its disciplinary process. It also establishes a requirement that the CMEB refer all findings of no probable cause to a medical hearing panel within 60 days of receipt from the DPH. The CMEB and medical hearing panels are comprised of volunteers who are not compensated for their time. Therefore, no direct state cost will result from an increased workload of their members.

Section 6 requires the DPH to include additional information related to medical malpractice investigations in its annual report to the General Assembly. The department will incur FY 05 costs of $92,940 to support the salary of one half-time Office Assistant (at an annual salary of $17,440) needed to enter data not presently collected and/or entered into the agency's database, one-time associated equipment

[1] The fringe benefit costs for state employees are budgeted centrally in the Miscellaneous Accounts administered by the Comptroller. The total fringe benefit reimbursement rate as a percentage of payroll is 45.82%, effective July 1, 2003. However, first year fringe benefit costs for new positions do not include pension costs - lowering the rate to 20.23% in FY 05. The state's pension contribution is based upon the prior year's certification by the actuary for the State Employees Retirement System.

costs of $3,000, and costs of one-time data processing services (approximately $72,500) needed to revise the agency's computer database and develop reporting tools. In FY 06 this cost will fall to $17,440, as the consultant services will no longer be required. DPH costs will be supplemented by fringe benefit costs of $3,530 in FY 05 and $7,990 in FY 06.

Section 7 requires each hospital or outpatient surgical facility to establish protocols for screening patients prior to any surgery, and submit copies of the same annually to the DPH with a report on their implementation. The development and implementation of these protocols will lead to additional costs for the John Dempsey Hospital at the University of Connecticut Health Center. However, given the required assistance of DPH in the development of these protocols as well as potential coordination with other hospitals in the state, these additional costs are expected to be minimal. To the extent that the measures in this bill lower medical malpractice and malpractice insurance costs, the John Dempsey Hospital may realize future savings. The extent of these savings cannot be determined at this time.

Section 8 makes changes to the offer of judgment provisions in current law. These changes are not expected to substantially alter the period of time it takes to dispose of civil cases on a system wide basis such that there would be a fiscal impact to the Judicial Department.

Section 10 requires each physician, podiatrist, chiropractor and naturopathic physician to report the name of the insurance company providing his or her professional liability insurance, the policy number, his or her area of specialization and whether he or she is actively involved in patient care. It also allows DPH to compare this information to that contained in the National Practitioner Data Base.

Section 11 requires the DPH to report, by January 1, 2005, and annually thereafter, on the number of physicians by specialty who are actively providing patient care.

The DPH will incur FY 05 costs of $70,600 to support the salaries of one Office Assistant (at an annual salary of $34,870), and one half-time Systems Developer (at an annual salary of $31,230) needed to revise the agency's existing licensure database, enter information, follow-up with physicians who fail to supply the required data, and compile the annual report. Also included in this sum are one-time costs for equipment ($3,000) and reprinting the physician renewal card ($1,500). In FY 06 this cost will fall to $66,100 as one-time equipment and printing costs will not recur. DPH costs will be supplemented by fringe benefit costs of $6,320 in FY 05 and $14,310 in FY 06. It is anticipated that DPH will conduct few National Practitioner Data Bank checks, since each query costs $4.25 and no funding has been appropriated to the department for this purpose within sHB 5033.

The DPH will incur FY 05 costs of $70,600 to support the salaries of one Office Assistant (at an annual salary of $34,870), and one half-time Systems Developer (at an annual salary of $31,230) needed to revise the agency's existing licensure database, enter information, follow-up with physicians who fail to supply the required data, and compile the annual report. Also included in this sum are one-time costs for equipment ($3,000) and reprinting the physician renewal card ($1,500). In FY 06 this cost will fall to $66,100 as one-time equipment and printing costs will not recur. DPH costs will be supplemented by fringe benefit costs of $6,320 in FY 05 and $14,310 in FY 06. It is anticipated that DPH will conduct few National Practitioner Data Bank checks, since each query costs $4.25 and no funding has been appropriated to the department for this purpose within sHB 5033.

Section 12 requires medical malpractice insurance companies to offer a premium discount on the policy to any insured that qualifies. This does not result in a fiscal impact.

Section 13 requires the quasi-public, Connecticut Health and Educational Facilities Authority (CHEFA) to establish a program to provide grants to hospitals to install or upgrade electronic health record systems for the establishment and maintenance of patient

records and verification of patient treatment. The scope of this program, in conjunction with the program provided for in **Section 24** of the bill, would be determined by the level of reserves in the CHEFA fund that would otherwise be unallocated or could be reallocated from future discretionary grants. (At present, the CHEFA fund has a grant reserve of $1 million and a contingency reserve of approximately $1.3 million.)

Section 14 requires medical malpractice insurance companies to file a request for rate approval with the Insurance Commissioner 60 days prior to the effective date. This has no fiscal impact on the Department of Insurance.

Sections 15 & 16 require that captive insurers submit an application and a nonrefundable fee of $175 to the Insurance Commissioner in order to obtain a certificate of authority. Furthermore, the captive insurer must pay all expenses incurred as a result of filing the application. Currently, it is unknown how many captive insurers are in the state, as it is not a regulated industry. The bill also authorizes the commissioner, upon determination, to impose a civil penalty, with a maximum fine of $10,000. This will result in minimal revenue gain.

Section 17 requires the court to grant any waiver of attorneys' contingency fees in medical malpractice cases. There is no related fiscal impact.

Section 18 requires the Insurance Commissioner to create and maintain an information database. The department already collects much of the information that the bill requires. This does not result in a fiscal impact.

Section 19 establishes a Patient Safety Ombudsman within the DPH, whose duties include establishing a patient safety and medical errors program, creating an education and research program on issues relating to the causes and consequences of medical errors, establish a clearinghouse for reporting on best practices, coordinate data collection and analysis needed to develop programs that promote

patient safety, coordinate state and federal patient safety programs and participate in the Federal Patient Safety Improvement Corps. To comply with these mandates the department will incur FY 05 costs of $136,330 to support the salaries of one Public Health Services Manager (at an annual salary of $80,560) and one Epidemiologist 2 (at an annual salary of $52,770). Also included are one-time equipment costs of $3,000. In FY 06 this cost will fall to $133,330 as one-time equipment costs will not recur. DPH costs will be supplemented by fringe benefits costs of $26,970 in FY 05 and $61,090 in FY 06. No funding has been included within sHB 5033 for this purpose.

Section 20 requires the court to review jury verdicts in medical malpractice cases exceeding $1 million to determine if the non-economic damages are excessive. The court could accommodate such reviews through a workload increase, which would not require additional appropriations.

Section 21 results in an estimated revenue loss of $7.5 million - $11.25 million annually to the General Fund by allowing health care providers to deduct any amount paid from medical malpractice insurance premium from their adjusted gross income for Connecticut state income tax purposes. Total reported medical malpractice premiums for all health care providers and entities paid in Connecticut in 2002 were $180 million of which an estimated $120 million were associated with doctors only (not including other health care professionals). However, additional unreported premiums could add an additional 25% to these totals. Applying the highest marginal personal income tax rate (5%) to these estimates yields a revenue loss of $7.5 million to $11.25 million per year.

Section 22 finances the medical malpractice insurance premium tax deduction (Section 21) and the loan forgiveness program (Section 23) by requiring that funding for them come from the $111 million transferred from the Tobacco Settlement Fund (TSF) to the General Fund. The total estimated General Fund revenue loss for the tax deduction is $7.5 million to $11.25 million. The loan forgiveness

program will also result in a General Fund revenue loss but the amount cannot be estimated at this time. It should be noted that the bill would require that the FY 05 revenue estimates to be readopted so that the amount needed to fund the loan forgiveness program could be identified.

An estimated $113.0 million will be received by Connecticut from tobacco companies per the Master Settlement Agreement in FY 05. The FY 05 revenue estimates adopted by the Finance Committee reflect a transfer of $111.0 million from the TSF to the General Fund. The remaining $2.0 million is to be deposited to the Biomedical Research Trust Fund.

Section 23 establishes a loan forgiveness program for individuals completing medical training in obstetrics and neurosurgery at medical schools in the state.[2] In order to be eligible for the program, a person would be required to practice as a licensed physician or surgeon in the state for 5 years. On average, medical students accumulate about $90,000 in loans. Passage of this provision of the bill would result in significant costs. Some of the possible factors that would determine these costs may include the number of participants, the amount of loans, and the incentive created by the program to enter the specified fields.[3] The bill also provides that the Board of Governors of Higher Education would establish the procedures to administer the program. There would also be costs associated with the program's administration including marketing, recruiting and monitoring compliance.

Section 24 requires CHEFA to establish a pilot program to provide grants to hospitals to provide medical malpractice indemnity or insurance to physicians and surgeons who enjoy privileges at the

[2] According to the University of Connecticut Health Center, there are about 6 residents in obstetrics annually and 1 in neurosurgery every other year.

[3] Medical students choose their field once they are residents and no longer students. Furthermore, individuals who go to school in one state generally do their residency in another. Thus, based on the additional cost of medical insurance in these fields, it is anticipated that the incentive would have to be significant.

hospital. Such program shall not exceed $750,000. (See the analysis in **Section 13**.)

Section 25 eliminates the voluntary medical malpractice-screening panel.

OLR BILL ANALYSIS

sHB 5669

AN ACT CONCERNING MEDICAL MALPRACTICE INSURANCE REFORM

SUMMARY:
This bill makes numerous changes to the laws dealing with civil litigation; insurance regulation and oversight; and the regulation, oversight, and disciplining of doctors.

Civil Litigation Reform

The bill:

1. establishes a mandatory mediation program for medical malpractice lawsuits filed after the bill becomes law,

2. requires, as a condition of filing a medical malpractice lawsuit or an apportionment complaint in such a lawsuit, that a signed opinion of a similar health care provider be prepared to show the existence of a good faith belief that there has been negligence and a copy be attached to the lawsuit complaint;

3. reduces the amount of interest that a defendant must pay under the offer of judgment law from a flat rate of 12% to 6% on that portion of the award that exceeds twice the amount specified in the offer of judgment;

4. allows the attorney fee schedule for contingency fees in medical malpractice cases to be waived only upon an application to and approval by a judge, the burden on the claimant's attorney to show that deviation from the schedule is warranted due to the nature of the case, and limits the fee to 1/3rd of the amount of the award or settlement; and

5. eliminates the Medical Malpractice Screening Panel.

Insurance Regulation and Oversight

The bill:

1. requires insurance companies to offer discounts to health care providers that maintain electronic health records;

2. requires prior rate approval by the Insurance Department for all medical malpractice insurance rates;

3. requires captive insurers to get a certificate of authority from the Insurance Department and provide it with certain financial information and establishes a $175 fee for the issuance or renewal of a certificate of authority; and

4. beginning June 1, 2005, requires entities that insure people or entities against medical malpractice lawsuits to provide the insurance commissioner with a closed claim report on each malpractice claim that the insurer closes. The report must include details about the insured and insurer, the injury or loss, the claims process, and the amount paid. The bill requires the commissioner to compile and analyze the data and annually submit a report on this to the Insurance and Real Estate Committee and the public.

Regulation, Oversight, and Discipline of Medical Providers

The bill:

1. requires the plaintiff or his attorney to mail a copy of a medical malpractice complaint to the Department of Public Health (DPH) and the Insurance Department when he files a lawsuit against a licensed physician and certain other licensed health care providers, and requires DPH to determine if there is a basis for further investigations or disciplinary action;

2. requires anyone who pays a medical malpractice award or settlement to provide copies of the award or settlement and complaint and answer, if any, to the Insurance Department instead of just DPH;

3. requires those paying medical malpractice awards or settlements for licensed physicians and certain other health care providers to provide additional information to DPH, including a breakdown by

economic and noneconomic damages;

4. requires DPH to adopt guidelines to determine the basis for further investigation or disciplinary action regarding physicians who paid damages or were sued;

5. requires DPH and the insurance commissioner to develop systems to collect, store, use, interpret, report, and provide public access to such information;

6. makes release of liability invalid until the attorney representing the paying party files an affidavit with the court that he has provided DPH and the insurance commissioner with the required information;

7. requires DPH to adopt regulations establishing guidelines for screening complaints, prioritizing investigations, and determining when an investigation should be broadened;

8. requires the Medical Examining Board, with DPH's assistance, to adopt guidelines for its disciplinary process and requires the DPH commissioner to conduct a hearing on charges against a doctor if a hearing panel the board appoints has not done so within 60 days after the board reports charges to it;

9. requires that any finding of no probable cause by DPH after investigation be reviewed by a hearing panel the board appoints and authorizes the panel to ask DPH to provide more information or reconsider its findings;

10. requires that DPH's annual report to the governor and Public Health Committee include additional information such as the number of complaints filed against doctors, and the number of notices of malpractice lawsuits filed that were not investigated and the reasons why;

11. requires hospitals and outpatients surgical facilities to establish certain presurgery protocols;

12. requires DPH to notify those who file petitions with it against doctors when it makes a finding of no probable cause and indicate the reason for its finding;

13. requires doctors annually to provide certain information to DPH, including their malpractice insurer, policy number, area of specialization, and disciplinary actions and malpractice payments made in other jurisdictions;

14. requires DPH to report annually the number of doctors, by specialty, who are actively providing patient care; and

15. requires the Connecticut Health and Educational Facilities Authority (CHEFA) to establish a grant program for hospitals to upgrade their health record system;

16. requires CHEFA to establish a pilot program called the Connecticut Physician Insurance Program, within available appropriations, to finance and provide grants of up to $750,000 in the aggregate to nonprofit hospitals to provide medical malpractice indemnity or insurance to physicians and surgeons who enjoy privileges at the hospitals;

17. requires the Board of Governors of Higher Education, in consultation with the Connecticut Medical Examining Board and the public health commissioner, to establish a program to forgive loans the state provides to individuals to complete medical training in obstetrics or neurosurgery at a medical school in this state accredited by the Liaison Committee on Medical Education or the American Osteopathic Association; and

18. requires the DPH commissioner to designate a patient safety ombudsman within DPH to improve patient safety and reduce medical errors by (1) coordinating state initiatives on patient safety, (2) facilitating ongoing collaborations between the public and private sectors, and (3) promoting patient safety through education of health care providers and patients.

The bill allows licensed physicians to deduct from their Connecticut adjusted gross income for state income tax purposes any amount they paid for premiums on a medical malpractice insurance policy.

Finally, the bill requires that money for the loan forgiveness program and to offset the tax losses caused by the deductions come from the Tobacco Settlement Fund.

EFFECTIVE DATE: The bill takes effect upon passage, except the provisions dealing with discounts and loans for electronic records, educational loan forgiveness, disbursements from the tobacco settlement fund, and the pilot program for hospitals, which become effective July 1, 2004; the provision dealing with captive insurers, which becomes effective October 1, 2004; and the provision requiring the data on closed cases, which becomes effective January 1, 2005.

MANDATORY MEDIATION (§ 1) NEW

The bill establishes a mandatory mediation program for all medical malpractice lawsuits filed after the bill becomes law to:

1. review the good faith certificate filed to determine whether there are grounds for a good faith belief that the defendant was negligent in the claimant's care or treatment,

2. attempt to achieve a prompt settlement or resolution of the case, and

3. expedite the litigation of the case.

The bill requires the court clerk to refer the case to a judge of the Superior Court for mediation when the defendant files his answer. The mediation must occur within 30 days after the answer is filed or later if the court grants a continuance. The bill specifies that mediation does not stay or delay the of the lawsuit, or delay discovery.

At the mediation, the court must review the certificate of good faith to determine whether there are grounds for a good faith belief that the defendant has been negligent in the claimant's care or treatment. If the court determines that the certificate is inadequate to permit such a determination, it may order the party submitting it to file, within 30 days, a supplemental certificate stating the grounds for the opinion that there has been negligence in the claimant's care or treatment.

If the court determines that the certificate or any supplemental certificate is inadequate to support a determination that there are grounds for a good faith belief that there has been negligence, it must order the party asserting the claim to post a $5,000 cash or surety bond

as a condition of continuing the case. The bond must be used to pay the other party's taxable costs if the case is not successfully prosecuted.

The bill requires all parties to the case, together with a representative of each insurer that may be liable, to attend the mediation in person, unless attendance by means of telephone is permitted upon written agreement of all parties or written order of the court.

If the mediation does not settle or conclude the case, the court must enter whatever orders are necessary to narrow the issues, expedite discovery, and help the parties prepare the case for trial.

GOOD FAITH CERTIFICATE (§ 2)

Current law prohibits filing malpractice lawsuits unless the attorney or claimant has made a reasonable inquiry as permitted by the circumstances to determine that there are grounds for a good faith belief that the claimant received negligent care or treatment. The complaint or initial pleading must contain a certificate of the attorney or claimant that such reasonable inquiry resulted in a good faith belief that grounds exist for a lawsuit against each named defendant.

Under current law, a good faith belief may be shown if the claimant or his attorney receives a written opinion from a similar health care provider that there appears to be evidence of medical negligence (see BACKGROUND). The bill instead requires that there be a written opinion to show the existence of good faith. It requires that the opinion include a detailed basis for the opinion.

The bill requires the claimant or his attorney to retain the original written opinion and attach a copy of it to the complaint, with the similar health care provider's name and signature removed.

The bill imposes the same good faith certificate requirement on defendants who file an apportionment complaint against another health care provider as applies to the plaintiff. (An apportionment complaint is a claim by a health care defendant in a medical malpractice lawsuit that another health care provider who the plaintiff did not make a defendant committed malpractice and partially or totally caused the plaintiff's damages. By filing the apportionment complaint, the defendant in essence adds the other health care provider as party to the plaintiff's malpractice lawsuit.)

Under the bill, if a plaintiff asserts a claim against a party added to the case by a defendant by an apportionment complaint, he is not required to make a reasonable inquiry and submit a certificate of good faith regarding such person.

The bill makes the health care provider who provides the opinion immune from liability unless it is shown he acted with malice.

By law, the court may impose sanctions if a certificate was not made in good faith (see BACKGROUND).

NOTICE OF LAWSUITS TO DPH (§ 3)

The bill requires that upon filing a medical malpractice case against certain health care providers, the plaintiff or his attorney mail a copy of the complaint to the DPH and the Insurance Department. The requirement applies to lawsuits filed against licensed physicians, chiropractors, naturopaths, dentists, and psychologists.

Existing law requires that anyone who pays damages in any medical malpractice case notify DPH of the terms of the award or settlement and provide a copy of the award or settlement and the underlying complaint and answer, if any. The bill requires that it specify the portion attributable to economic damages and the portion attributable to noneconomic damages. It also requires that if there are multiple defendants, the information include the allocation for payment of the award between or among such defendants.

The bill (1) requires that the person who pays damages also provide this information to the Insurance Department, (2) specifies that the copies provided to the department may not identify the parties to the claim, and (3) requires that DPH send this information to the state board of examiners that oversees the health care provider who was a defendant in the lawsuit.

Under current law, DPH must review all medical malpractice awards and all settlements to determine whether further investigation or disciplinary action against the providers involved is warranted. The bill requires that DPH review all malpractice claims as well. It requires that, beginning October 1, 2004, DPH conduct its reviews in accordance with guidelines DPH adopts to determine the basis for such further investigation or disciplinary action.

The bill requires the DPH and insurance commissioners to develop systems within their respective agencies for collecting, storing, using, interpreting, reporting, and providing public access to the information they receive. It requires each commissioner to report the details of such systems within its agency to the Public Health and Insurance and Real Estate committees by October 1, 2004.

Release of Liability

Under current law and practice, people receiving a settlement in a malpractice claim sign a liability release to the person or entity paying the settlement. The bill makes such releases in connection with malpractice claims against certain health care providers invalid until the attorney for the entity making payment on behalf of a party or, if no such entity exists, the attorney for the party, files with the court an affidavit stating that he has provided the information the bill and law require to DPH and the Insurance Department. The requirement applies to claims against licensed physicians, chiropractors, naturopaths, dentists, and psychologists.

DPH INVESTIGATION OF COMPLAINTS AGAINST PHYSICIANS (§ 4)

By law, the DPH commissioner, with the Connecticut Medical Examing Board's advice and assistance, may establish regulations to carry out its oversight and regulatory duties. The bill requires the commissioner, by July 1, 2004, to adopt regulations that establish (1) guidelines for screening complaints that physicians may be unable to practice medicine with reasonable skill and safety to determine which complaints will be investigated; (2) a prioritization system for conducting investigations to ensure prompt action when it appears necessary; and (3) guidelines to determine when an investigation should be broadened beyond the initial complaint to include sampling patient records to identify patterns of care, reviewing office practices and procedures, reviewing performance and discharge data from hospitals and managed care organizations, and additional interviews of patients and peers.

DISCIPLINARY PROCEEDINGS AGAINST DOCTORS (§ 5)

The 15-member Connecticut Medical Examining Board is empowered to restrict, suspend, or revoke the license of a physician or limit his right to practice for certain misconduct.

The bill requires that by December 31, 2004, the board, with DPH's assistance, adopt regulations that establish guidelines for use in the disciplinary process. The guidelines must include, but need not be limited to (1) identification of each type of violation; (2) minimum and maximum penalties for each type of violation; (3) additional optional conditions that the board may impose for each violation; (4) identification of factors the board must consider in determining if the maximum or minimum penalty should apply; (5) conditions, such as mitigating factors or other facts, that may be considered in allowing deviations from the guidelines; and (6) a provision that when a deviation from the guidelines occurs, the reason for the deviation must be identified.

By law, the board must refer all statements of charges DPH files with it to a medical hearing panel within 60 days of receiving them. Also by law, the panel must conduct a hearing on contested cases. The panel must file a proposed final decision with the board within 120 days of the receipt of the issuance of the notice of hearing by the board. The board may, for good cause, vote to extend both of these deadlines.

The bill requires that each hearing panel must consist of three members, one of whom must be a Connecticut Medical Examining Board member and one a public member. The public member may be a board member.

The bill requires the DPH commissioner to conduct the hearing if the panel has not done so within 60 days of the date of referral of the statement of charges by the board. The hearing must be conducted in accordance with the regulations the commissioner adopts concerning contested cases. The bill requires the commissioner to file a proposed final decision with the board within 60 days after the hearing. The board may extend the filing deadlines in a recorded vote.

The bill requires the board to refer all findings of no probable cause that DPH files with it to a medical hearing panel within 60 days of receiving the charges. The board may extend this deadline for good cause by a duly recorded vote. The panel must review the petition and the entire record of the investigation and may ask DPH to provide more information or reconsider its finding. If the panel takes no action within 90 days after DPH submits the finding to the board it is considered final.

DPH GUIDELINES FOR REVIEW OF MALPRACTICE AWARDS AND SETTLEMENTS (§ 6)

By law, DPH must file with the governor and Public Health Committee an annual report of its disciplinary activities, which must include certain information. The bill requires that the report specify (1) the number of petitions and lawsuit notices not investigated and the reasons why, (2) the outcome of the hearings held on such petitions and notices, and (3) the timeliness of action taken on petitions and notices considered to be a priority.

PRE-SURGICAL PROTOCOLS (§ 7)

The bill requires each licensed hospital or outpatient surgical facility to establish protocols for screening patients before surgery. These protocols must require that before surgery, the principal surgeon and four other people employed by or associated with the hospital or facility (1) identify the patient and, where the patient is able to do so, have the patient identify himself and (2) identify the procedure to be performed. They must also require that all five team members confirm the identification process before any patient is anesthetized or surgery performed. But, the bill allows the protocols to provide for alternative identification procedures where the patient is unconscious or under emergency circumstances. It requires each licensed hospital or outpatient surgical facility annually to submit to DPH a copy of the protocols and a report on their implementation.

The bill directs DPH to assist each hospital or outpatient surgical facility to develop and implement these screening protocols.

OFFER OF JUDGMENT (§ 8)

Under current law, the plaintiff in a contract case or a case seeking money damages may, up to 30 days before trial, file with the court clerk a written "offer of judgment" offering to settle the claim for a specific amount. After trial, the court must examine the record to determine whether the plaintiff made an offer of judgment, which the defendant failed to accept. If it determines that the plaintiff recovered an amount equal to or greater than the sum stated in the plaintiff's offer of judgment, the court must add 12% annual interest.

By law, a defendant has 60 days to file with the clerk an acceptance of

the offer. The bill allows the court to grant the defendant one or more extensions of up to 120 additional days to file an acceptance.

The bill changes the interest rate the court may award with respect to an offer of judgment for causes of action that accrue after the bill's effective date. It does so by reducing from 12% to 6% the interest the court must add to the portion of the award that exceeds twice the amount stated in the offer of judgment.

DPH INVESTIGATION OF PETITIONS (§ 9)

The law requires DPH to investigate each petition filed with it to determine if probable cause exists to issue a statement of charges and institute proceedings against the physician.

Under current law, the investigation must be concluded within 18 months from the date the petition was filed. The investigation is confidential and no one may disclose his knowledge of it to a third party unless the physician asks that the investigation be opened. If DPH determines that probable cause exists to issue a statement of charges, the entire record is public unless it determines the physician is an appropriate candidate for participation in a rehabilitation program and the physician agrees to participate in accordance with terms agreed upon by DPH and the physician. If after the filing of a petition and during the 18-month period, DPH makes a finding of no probable cause, the petition and the entire record of the investigation must remain confidential unless the physician asks that such petition and record be open. The bill specifies that the investigation remain confidential only if the medical panel the board appointed allows the finding of no probable cause to stand.

The bill requires DPH to notify the person who filed a petition or his legal representative when it makes a finding of no probable cause. It must include the reason for such finding.

DPH DATA REGARDING PRACTITIONERS (§ 10)

By law, each person holding a license to practice medicine, surgery, podiatry, chiropractic or naturopathy must register annually with DPH and provide his name, residence, and business address, and other information DPH requests. The bill also requires the licensee to provide the name of the insurance company providing his malpractice

insurance and the policy number, his area of specialization, whether he is actively involved in patient care, and any disciplinary action against him or malpractice payments made on his behalf in any other state or jurisdiction. The bill authorizes DPH to compare the information submitted to information contained in the National Practitioner Data Base.

NUMBER OF PHYSICIANS (§ 11)

The bill requires DPH by January 1, 2005, and annually thereafter, to report to the Senate and House clerks, the state librarian, and the Office of Legislative Research the number of physicians by specialty who are actively providing patient care in Connecticut.

REQUIRED DISCOUNTS—ELECTRONIC HEALTH RECORDS (§ 12)

The bill requires medical malpractice insurance companies to offer a premium discount on a policy to any insured that submits to the insurer proof that it will use an electronic health record system during the premium period to establish and maintain patient records and verify patient treatment. The discount must be at least 10% of the premium for a period of one year from the effective date of the policy or renewal.

GRANTS FOR ELECTRONIC HEALTH RECORD SYSTEMS (§ 13)

The bill requires the Connecticut Health and Educational Facilities Authority to establish the Connecticut Electronic Health Records Program, within available appropriations, to finance grants to hospitals to install or upgrade electronic health record systems for establishing and maintaining patient records and verifying of patient treatment in order to promote patient safety and eliminate errors.

PRIOR RATE APPROVAL (§ 14)

The bill subjects malpractice insurance rates for physicians and surgeons, hospitals, or advanced practice registered nurses to prior rate approval by the insurance commissioner. On and after the bill's effective date, each insurer or rating organization seeking to change its rates for such insurance must (1) file a request for such change with the Insurance Department and (2) provide written notice to its insureds of any request for a rate increase.

They must file the request and send the notice at least 60 days before the change's effective date. The notice must indicate that a public hearing will be held. The Insurance Department must review the request and, hold a public hearing on the rate increase before approving or denying it. The bill gives the commissioner 45 days to approve or deny the request. Her findings may be appealed to Superior Court.

CAPTIVE INSURERS (§§ 15 AND 16)

Beginning October 1, 2004, the bill prohibits captive insurers from insuring a health care provider or entity in Connecticut against liability for medical malpractice unless it has obtained a certificate of authority from the insurance commissioner. It does not require a certificate of authority for captive insurers duly licensed in Connecticut to offer such insurance. The bill establishes a $175 fee for each certificate issued.

A "captive insurer" is an insurance company owned by another organization whose exclusive purpose is to insure risks of the parent organization and affiliated companies. In the case of groups and associations, it is an insurance organization owned by the insureds whose exclusive purpose is to insure risks of member organizations and group members and their affiliates.

Application to Insurance Commissioner

The bill requires any captive insurer seeking to obtain a certificate of authority to apply to the commissioner, on such form as she requires, specifying the line or lines of business that it is seeking authorization to write. The captive insurer must file with the commissioner (1) a certified copy of its charter or articles of association, (2) evidence satisfactory to the commissioner that it has complied with the laws of the jurisdiction under which it is organized, (3) a statement of its financial condition together with whatever evidence of its correctness the commissioner requires, and (4) evidence of good management in such form as the commissioner requires.

The bill requires the captive insurer to submit evidence of its ability to provide continuous and timely claims settlement. It authorizes the commissioner to issue to such insurer a certificate of authority permitting it to do business in Connecticut if she finds that information

furnished is satisfactory and the insurer complied with all other requirements of law. The certificate expires on the first day of May following the date of its issuance, but may be renewed without any formalities except as the commissioner requires.

The bill requires the commissioner to adopt regulations specifying the information and evidence that a captive insurer seeking to obtain or renew a certificate of authority must submit and the requirements with which it must comply.

Cause for Revocation

Under the bill, the failure of a captive insurer to exercise its authority to write a particular line or lines of business in Connecticut for two consecutive calendar years may constitute sufficient cause for revoking its authority to write those lines of business.

The bill authorizes the commissioner, for cause, after notice and a hearing, to suspend, revoke, or refuse to renew a certificate of authority. She may also impose a fine of up to $10,000. She or her designee may hold the hearings. The bill mandates that whenever any one other than the commissioner acts as the hearing officer, the person must submit to the commissioner a memorandum of findings and recommendations upon which she may base a decision. The commissioner may, if she deems it in the public interest, publish in one or more state newspapers a statement that she has suspended or revoked the certificate of authority of any captive insurer to do business in Connecticut.

The bill requires the applicant to pay all expenses the commissioner incurs in connection with the authority and duties the bill establishes with respect to a captive insurer.

Any captive insurer aggrieved by the commissioner's action in revoking, suspending, or refusing to reissue a certificate of authority, or in imposing a fine may appeal to Superior Court. The appeal must be filed in the New Britain Judicial District.

CONTINGENCY FEE (§ 17)

Current law establishes a sliding scale on contingency fees attorneys may charge clients. It establishes an upper limit on contingency fees attorneys may collect from their clients based on the amount of the

settlement or judgment. It allows (1) 33 1/3% of the first $300,000, (2) 25% of the next $300,000, (3) 20% of the next $300,000, (4) 15% of the next $300,000 and (5) 10% of amounts exceeding $1,250,000. This sliding scale applies to any lawsuit to recover damages resulting from personal injury, wrongful death, or property damage involving contingency fees, not just to medical malpractice cases. A Superior Court judge interpreted this law to alllow clients to waive its protections and agree to pay a higher contingency fee (see BACKGROUND).

The bill makes a fee a contingency fee arrangement with an attorney regarding a medical malpractice claim, which provides for a fee that would exceed the percentage limitations established in the sliding scale, invalid unless the claimant's attorney files an application with the court for approval, and the court, after a hearing, grants the application. But, the bill prohibits the court from approving a contingency fee that exceeds 33 1/3% of the damages awarded and received by the claimant, or of the settlement amount received by the claimant.

The bill requires the claimant's attorney to attach to the application a copy of such fee arrangement and the proposed unsigned writ, summons and complaint in the medical malpractice case. The fee arrangement must provide that the attorney will advance all costs in connection with the investigation and prosecution or settlement of the case and the claimant will not liable for the reimbursement for any such costs if there is no recovery.

The bill requires the court to grant the application if it finds that the case is sufficiently complex, unique, or different from other medical malpractice cases so as to warrant a deviation from the percentage limitations. At the hearing, the claimant's attorney has the burden of showing that the deviation is warranted.

If the court denies the application, it must advise the claimant of his right to seek representation by another attorney willing to abide by the percentage limitations. The court's decision to grant or deny the application may not be appealed. The filing of such application tolls the applicable statute of limitations until 90 days after the court's decision to grant or deny the application.

The bill requires the Chief Court Administrator to assign a judge or judges with experience in personal injury cases to hear and determine such applications.

The bill prohibits an attorney form requiring a claimant from paying interest on the amount of any disbursements and costs the attorney makes in connection with the investigation and prosecution or settlement of the malpractice claim.

Method by Which Fee is calculated

For all contingency fee arrangements, not just those involving medical malpractice cases, the bill requires that the percentages that go to the client and to the attorney be calculated after deductions for any disbursements or costs the attorney incurred, other than ordinary office overhead and expenses.

MEDICAL MALPRACTICE DATA BASE (§ 18)

Current law authorizes the insurance commissioner to require all insurance companies writing medical malpractice insurance in Connecticut to submit, in such manner and at such times as she specifies, whatever information she deems necessary to establish a database on medical malpractice. The database may include information on all incidents of medical malpractice, all settlements, all awards, other information relative to procedures and specialties involved, and any other information relating to risk management.

The bill eliminates this authority and instead, beginning January 1, 2005, requires each insurer to provide to the commissioner with a closed claim report, on whatever form she requires. A "closed claim" is a claim that has been settled, or otherwise disposed of, where the insurer has made all indemnity and expense payments on the claim. The duty to report applies to a captive insurer or a self-insured person.

The bill requires the insurer to submit the report within 10 days after the last day of the calendar quarter in which a claim for recovery under a medical liability policy is closed. The report must include information only about claims settled under Connecticut's laws. It must include details about the insured and insurer, the injury or loss, the claims process, and the amount paid on the claim.

Details About the Insured and Insurer

The bill requires details about the insured and insurer to include the (1) insurer's name, (2) professional liability insurance policy limits and whether the policy was an occurrence policy or was issued on a claims-made basis; (3) name, address, health care provider professional license number and specialty coverage of the insured; and (4) insured's policy number and a unique claim number.

Details About the Injury or Loss

The bill specifies that details about the injury or loss include the (1) date of the injury or loss that was the basis of the claim; (2) date the injury or loss was reported to the insurer; (3) name of the institution or location at which the injury or loss occurred; (4) type of injury or loss, including a severity of injury rating that corresponds with the injury scale that the commissioner must establish based on the severity of injury scale developed by the National Association of Insurance Commissioners; and (5) name, age, and gender of any injured person covered by the claim. Any individually identifiable information must be confidential.

Details About the Claims Process

The bill specifies that details about the claims process include (1) whether a lawsuit was filed, and if so, in which court; (2) the outcome of such lawsuit; (3) the number of other defendants, if any; (4) the stage in the process when the claim was closed; (5) the trial dates; (6) the date of the judgment or settlement, if any; (7) whether an appeal was filed, and if so, the date filed; (8) the resolution of the appeal and the date such appeal was decided; (9) the date the claim was closed; (10) the initial indemnity and expense reserve for the claim; and (11) the final indemnity and expense reserve for the claim.

Details About the Amount Paid on the Claim

The bill specifies that details about the amount paid on the claim include

1. the total amount of the initial judgment rendered by a jury or awarded by the court;

2. the total amount of the settlement if there was no judgment

rendered or awarded;

3. the total amount of the settlement if the claim was settled after judgment was rendered or awarded;

4. the amount of economic damages, or the insurer's estimate of the amount in the event of a settlement;

5. the amount of noneconomic damages, or the insurer's estimate of the amount in the event of a settlement;

6. the amount of any interest awarded due to failure to accept an offer of judgment;

7. the amount of any remittitur or additur;

8. the amount of final judgment after remittitur or additur;

9. the amount paid by the insurer;

10. the amount paid by the defendant due to a deductible or a judgment or settlement in excess of policy limits;

11. the amount paid by other insurers;

12. the amount paid by other defendants;

13. whether a structured settlement was used;

14. the expense assigned to and recorded with the claim, including, but not limited to, defense and investigation costs, but not including the actual claim payment; and

15. any other information the commissioner determines to be necessary to regulate the professional liability insurance industry with respect to medical professionals and entities, ensure the industry's solvency, and ensure that such liability insurance is available and affordable.

The bill requires the commissioner to establish an electronic database composed of closed claim reports.

Annual Data Summary

The bill requires the insurance commissioner to compile the data included in individual closed claim reports into an aggregated, summary format and prepare a written annual report of the summary data. The report must provide an analysis of closed claim information, including a minimum of five years of comparative data, when available; trends in frequency and severity of claims; itemization of damages; timeliness of the claims process; and any other descriptive or analytical information that would assist in interpreting the trends in closed claims.

The bill requires the annual report to include a summary of rate filings for professional liability insurance for medical professionals and entities that the department approved for the prior calendar year. The summary must include an analysis of the trend of direct losses, incurred losses, earned premiums, and investment income as compared to prior years. The report must also include base premiums charged by medical malpractice insurers for each specialty and the number of providers insured by specialty for each insurer.

The bill requires that by March 15, 2006, and annually thereafter, the commissioner must submit the annual report to the Insurance and Real Estate Committee. She must also (1) make the report available to the public, (2) post it on the department's Internet site, and (3) provide public access to the contents of the electronic database after establishing that the names and other individually identifiable information about claimants and practitioners have been removed.

The bill requires the insurance commissioner to provide the DPH commissioner with electronic access to all the closed case information she receives.

PATIENT SAFETY OMBUDSMAN (§ 19)

The bill requires the DPH commissioner to designate a patient safety ombudsman within DPH to improve patient safety and reduce medical errors by (1) coordinating state initiatives on patient safety, (2) facilitating ongoing collaborations between the public and private sectors, and (3) promoting patient safety through education of health care providers and patients.

Duties of Ombudsman

The patient safety ombudsman must:

1. establish a Patient Safety and Medical Errors Program;

2. create an education and research program for the health care industry and the public on issues relating to the causes and consequences of medical errors;

3. establish a clearinghouse for reporting on best practices that improve patient safety;

4. coordinate data collection and analysis, in conjunction with other offices in the DPH, to develop programs that promote patient safety;

5. coordinate state and federal patient safety programs; and

6. participate in the federal Patient Safety Improvement Corps to identify the causes of medical errors.

The bill requires that, by January 1, 2005, and annually thereafter, the ombudsman submit a report to the governor and the Public Health chairpersons describing the progress in completing his duties, activities undertaken, and the groups and number of persons served, and making recommendations for future action.

MANDATORY REVIEW OF NONECOMOMIC DAMAGES EXCEEDING $1,000,000 (§ 20)

The bill requires the court, in any medical malpractice case in which the jury awards more than $1,000,000 in noneconomic damages, to review the evidence to determine if the amount of noneconomic damages is excessive as a matter of law. Specifically, the bill requires the court to consider whether it so shocks the sense of justice as to compel the conclusion that the jury was influenced by partiality, prejudice, mistake, or corruption. If the court concludes the award was excessive, it must order the plaintiff to remit the excessive amount. If the plaintiff refuses to do so, the court must set aside the verdict and order a new trial.

TAX DEDUCTION FOR LICENSED PHYSICIANS (§ 21)

The bill allows licensed physicians to deduct from their Connecticut adjusted gross income for state income tax purposes any amount they paid for premiums on a medical malpractice insurance policy. They may do so for tax years beginning January 1, 2004, January 1, 2005, and January 1, 2006.

TOBACCO SETTLEMENT FUND DISBURSEMENTS (§ 22)

By law, disbursements from the Tobacco Settlement Fund must ordinarily be made as follows: (1) $12 million to the Tobacco and Health Trust Fund, (2) $4 million to the Biomedical Research Trust Fund, (3) an amount to the General Fund set in the General Fund revenue schedule adopted by the General Assembly; and (4) any remainder to the Tobacco and Health Trust Fund.

The bill requires for FY 2004-05 and all subsequent fiscal years, that the amount to the General Fund set in the revenue schedule include an amount equal to (1) the total exemptions claimed by physicians for premiums on professional liability insurance policies pursuant to the bill and (2) the amount identified in the General Fund revenue schedule as necessary to fund the program for the forgiveness of loans program the bill establishes.

LOAN FORGIVENESS PROGRAM (§ 23)

The bill requires the Board of Governors of Higher Education, in consultation with the Connecticut Medical Examining Board and the public health commissioner, to establish a program for forgiving loans the state provides to individuals to complete medical training in obstetrics or neurosurgery at a medical school in Connecticut accredited by the Liaison Committee on Medical Education or the American Osteopathic Association. Under the bill, a person is eligible if he obtains a license as a physician and practices in Connecticut as a physician or surgeon in the field of obstetrics or neurosurgery for at least five years. The board of governors, in consultation with the Connecticut Medical Examining Board and the public health commissioner must adopt regulations to establish procedures to administer the program.

PILOT PROGRAM FOR HOSPITALS (§ 24)

The bill requires the Connecticut Health and Educational Facilities Authority to establish the Connecticut Physician Insurance Program as a pilot program, within available appropriations, to finance and provide grants of up to $750,000 in the aggregate to nonprofit hospitals to provide medical malpractice indemnity or insurance to physicians and surgeons who enjoy privileges at the hospitals. The indemnity or insurance must be provided through any risk management program or insurance the hospital maintains. The bill authorizes a hospital to apply for a grant on such form as the authority prescribes.

ELIMINATION OF MALPRACTICE SCREENING PANEL (§ 25)

The bill eliminates the voluntary Medical Malpractice-Screening Panel.

Under current law, the parties must consent to use the panel. In accordance with their mutual agreement, the insurance commissioner or her designee selects panel members from lists of names submitted by the Connecticut State Medical Society and the Connecticut Bar Association. The panel is composed of two doctors and one attorney with trial experience in personal injury cases who acts as chairman. One of the doctors must practice in the same specialty as the defendant. Panel members cannot be from communities in which the defendant doctor or the parties' attorneys practice. Panel members are not compensated. The panel holds confidential hearings when and where it decides and transcripts are available at cost to either party.

The panel's conclusion as to liability is outlined in a finding signed by the members and recorded by the insurance commissioner. The panel does not address the issue of damages. Each party receives a copy of the panel's findings. If a subsequent trial is held, only unanimous findings of the panel are admissible. The court or jury determines the weight assigned to such admissible findings. No member can be compelled to testify.

BACKGROUND

Related Bills

sSB 60, (File 165) makes numerous changes to tort law; insurance regulation; and the oversight, regulation, and discipline of doctors. It is very similar to sSB 394, but sSB 394 contains provisions for a fund to pay for malpractice insurance deductibles.

sSB 61, (File 166) establishes a fund to reimburse a portion of a malpractice claim, settlement, or judgment, which represents the deductible portion applicable to a provider's coverage. It authorizes the insurance commissioner to approve policies that contain deductibles up to $50,0000 for an individual and $100,000 for a hospital. It establishes another fund that pays a portion of a malpractice award or settlement that exceeds certain amounts. The maximum amount the fund may pay per claim is $500,000.

SB 141, (File 132) is based on the committee's investigation and report. The bill makes numerous changes to tort law, insurance regulation, and disciplining of health care providers. Tort reform provisions deal with such areas as offer of judgments, mediation, attorney's fees, elimination of the screening panel, and establish a task force to study alternatives to a tort system. Insurance provisions include prior rate approval, data gathering, and captive insurers.

Other provisions deal with investigatory complaints against doctors, the complaint investigation process and standards, data gathering, mandatory continuing education for doctors, and a task force to examine the feasibility of developing a doctor relicensing exam.

sSB 356, (File 431) makes numerous changes to tort law, insurance regulation and oversight, and the regulation, oversight, and discipline of medical providers. It is similar in many respects to SB 60, sSB 394, and sHB 5669. It makes the malpractice screening panel mandatory and does not require that the panel's findings be mandatory to be admissible in malpractice trials. It establishes a fund to pay the deductible portion of a malpractice premium up to certain limits. The fund is supported by assessments on malpractice awards or settlements.

sSB 394, (File 186) makes numerous changes to tort law; insurance regulation; and the oversight, regulation, and discipline of doctors. It is very similar to sSB 60 except it contains a provision for a fund. The insurance provisions relate to prior rate approval, captive insurers, data collection, and the requirement of certain companies to offer malpractice insurance. It establishes surgery protocols, electronic medical records, and investigation of doctors

sSB 566, revises the law requiring hospital and outpatient surgical facilities to report adverse events to DPH. It allows DPH to designate

as a "patient safety organization" a public or private organization whose primary mission involves patient safety improvement activities.

"Similar Health Care Provider"

By law, if the defendant health care provider is not certified by the appropriate American board as being a specialist, is not trained and experienced in a medical specialty, or does not hold himself out as a specialist, a "similar health care provider" is one who (1) is licensed by the appropriate regulatory agency of this state or another state requiring the same or greater qualifications and (2) is trained and experienced in the same discipline or school of practice. Such training and experience must be a result of active involvement in the practice or teaching of medicine within the five-year period before the incident giving rise to the claim.

If the defendant health care provider is certified by the appropriate American board as a specialist, is trained and experienced in a medical specialty, or holds himself out as a specialist, a "similar health care provider" is one who (1) is trained and experienced in the same specialty and (2) is certified by the appropriate American board in the same specialty. But, if the defendant health care provider is providing treatment or diagnosis for a condition, which is not within his specialty, a similar health care provider is a specialist trained in the treatment or diagnosis for that condition.

Sanctions if Certificate not Filed in Good Faith

By law, the court must impose an appropriate sanction upon the person who signed the certificate if it determines, after the completion of discovery, that the certificate was not made in good faith and that no valid issue was presented against a health care provider that fully cooperated in providing informal discovery. It may also impose the sanction on the claimant. The sanction may include an order to pay to the other party or parties the reasonable expenses incurred because of the filing of the pleading, motion, or other paper, including a reasonable attorney's fee. The court may also submit the matter to the appropriate authority for disciplinary review of the attorney if the claimant's attorney submitted the certificate.

Attorney Fees

Table 1 shows how the statutory formula under current law works for each of four hypothetical awards. It shows the actual amount of fees the statute allows the attorney to collect, the resulting percentage of the total award the attorney's fees constitute, the amount the client would receive, and the resulting percentage the client receives.

Table 1: Attorney's Fees for Various Damage Awards

Damage Award or Settlement	*Contingency Fee the Law Allows*	*Percentage of Total Award to Attorney*	*Amount Client Receives*	*Percentage of Total Award to Client*
$100,000	$33,333	33.33%	$66,667	66.67%
$500,000	$150,000	30%	$350,000	70%
$1,000,000	$250,000	25%	$750,000	75%
$5,000,000	$660,000	13.2%	$4,540,000	86.8%
$10,000,000	$1,160,000	11.6%	$8,840,000	88.4%

Waiver of Fee Schedule

Current law does not explicitly indicate whether a client can waive the contingency fee limits that the statute imposes. One Superior Court held that tort victims could waive their right to the protections afforded by the contingency fee law. The court also decided the plaintiff's waiver was valid, and the fee arrangement the plaintiff entered into with her attorney was reasonable (*In re Estate of Salerno,* 42 Conn. Supp. 526 (1993)).

The court resolved the case on nonconstitutional grounds, noting that rights granted by statute could be waived unless the statute is meant to protect the general rights of the public rather than private rights. It cited instances where statutes relating to litigation have been construed as conferring a private right that can be waived (e.g., statute of limitations for tort actions, right to trial by jury, defense of statute of fraud).

It concluded that the fee cap statute clearly confers a private right and does not protect the general rights of the public. It also cited the legislative history where proponents of the law indicated that the fee limits could be waived.

Complaints Against Doctors Filed With DPH

A person may file a petition against a doctor for the same reasons the Medical Examining Board may discipline a doctor. These include:

1. physical illness or loss of motor skill, including, but not limited to, deterioration through the aging process;

2. emotional disorder or mental illness;

3. abuse or excessive use of drugs or alcohol;

4. illegal, incompetent, or negligent conduct in the practice of medicine;

5. possession, use, prescription for use, or distribution of controlled substances or legend drugs, except for therapeutic or other medically proper purposes;

6. misrepresentation or concealment of a material fact in the obtaining or reinstatement of a license to practice medicine;

7. failure to adequately supervise a physician assistant;

8. failure to fulfill any obligation resulting from participation in the National Health Service Corps;

9. failure to maintain required professional liability insurance or other indemnity against liability for professional malpractice;

10. failure to provide information DPH requests to complete a health care provider profile;

11. performing any activity for which accreditation is required by law without appropriate accreditation required;

12. failure to provide evidence of accreditation required by law as requested by DPH;

13. and violation of any law regulating medicine and surgery or any regulation adopted under such laws.

COMMITTEE ACTION

Judiciary Committee

Joint Favorable Substitute
Yea 41 Nay 1